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A MANAGEMENT ACCOUNTING MODEL BASED ON THE LEGAL, ORGANIZAIONAL, AND FINANCIAL DEVELOPMENT OF A PRIVATIZED DEPARTMENT WITHIN A PUBLIC FACILITY AT POLYCLINIC NO.2 IN L'VIV UKRAINE

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SUMMARY

This document illustrates a management accounting model prepared for a department of surgery desiring to become privatized while operating within an 800 employee public outpatient clinic in L'viv, Ukraine.

The field work resulted in advancing the process of formulating a separate privatized legal entity, furthering the definition of an organizational structure, establishment of a prioritized physician performance management scheme, the definition of a new financial reporting requirements for the entity, and the creation, training, and implementation of essential management accounting tools to guide the entity into the near future including essential (and regulated) internal controls.

Management accounting methods are geared toward serving the decision-maker's needs in light of the legal, organizational, and financial framework of an entity. In that the legal, organizational, and financial structure had not been finalized when this field work commenced, a good deal of time and effort was spent to define and further the progress in these critical areas. This document summarizes the current framework for each of these areas, then illustrates the key aspects of the management accounting model. This includes the required internal controls, reports findings and recommendations for continuing the progress. The Annex contains additional information crucial to the model. Of particular usefulness is the overview of the new financial reporting requirements the entity must submit and a summary of the current tax liabilities private and public entities must submit. At this writing, a good portion of the Annex material is still in translation.

Significant considerations and constraints of the fieldwork were centered around three factors. First, the field work was being conducted as the process of obtaining governmental authorization to conduct the experiment and the supporting legal and licensing status was (and remains at this writing) underway. Marginal progress had been made in this regard since October of 1995. Second, there were still no computers available in the institution limiting the level of detail and complexity of the model. While this was a constraint, a rather value adding management accounting model was none the less created. Third, the principles and practices of management accounting were still new to the host managers of the facility thus requiring a fair degree of ongoing training of key stakeholders. However, the decisions that were desired to be made from such a system were fundamental in nature causing the need for "fancy" or complicated methods to be lowered. In consideration of this, a functioning model was designed, and, should computerization be made available, the model could easily be expanded and enriched without retracing steps or processes.

1. BACKGROUND AND INTRODUCTION

The basis for this work began with Task Order 334 when Abt Senior Political Economist Dr. Peter Hauslohner came to the Ukraine in September of 1995, in part to:

1. Clarify the legal, regulatory, and financial framework at the national level for establishing private medical services in the Ukraine with, in part, an emphasis on the possibility of privatizing state health facilities based on a grant of "concessions" to newly-privatized physicians practicing in specific departments, services, and/or entire facilities.

2. Clarify the legal, regulatory, and financial framework in the L'viv Oblast for establishing private medical practices, to identify those obstacles impeding the expansion of the privately provided services, and to develop recommendations to the L'viv Oblast health administration on ways to facilitate and accelerate expansion of the private provision of medical services within the region.

Hauslohner and John Stevens, L'viv Office Director, met with the Chief of the L'viv Oblast Health Administration to discuss these issues. The Chief agreed, in principle, to support such efforts at state run facilities. Specifically, it was suggested that publicly-financed "free" care be offered in government hospitals and polyclinics provided on the basis of a contractual arrangement between physicians and the respective facility. The physicians would organize their operations so as to provide "free" care to their catchment population but would also be allowed to solicit and serve fee-for service patients. Fees received from such services would be shared between the physicians and the facility. Hauslohner, Stevens, and the Oblast Administration verbally agreed that the 800 employee Polyclinic No. 2 in L'viv would be a suitable site to demonstrate such a model.

The original (basic) principles of the proposed pilot demonstration site at Polyclinic No. 2 included:

- The demonstration/experiment should last a fixed period of time, such as six months.
- The physicians delivering care under the pilot demonstration should be private physicians, not state employees.
- The provision of care should be specified in a formal agreement.
- The free care provided by the physicians should be financed by the state budget.
- Current payment levels from the state should be guaranteed
- Private physicians should be permitted to offer services offered on a "fee" basis and these fees should be shared among the parties to the agreement.
- Conditions for calculating and paying taxes should be defined and provided in a written agreement with the Oblast, Oblast tax officials, and the parties to the agreement noting that:
    - Profit, not income should be taxable
    - Capital equipment investments and repair, operating expenses including medicines, travel expenses, educational workshops, scientific literature and

similar expenses normal to the conducting of health care services are a cost of conducting business, and should be considered in the calculation of profit

- It should be possible to offset the liability of taxes by increasing the amount of free care offered.

1.1 Objectives and Scope of Work

A primary objective of Task 333 was to continue to introduce reforms in L'viv contributing to the establishment of a private medical practice. In addition, the task was intended to improve efficiency, quality, and access of patient services by: *implementing financial management systems related to user fees and privatization to ensure the efficient use and control of resources as health care facilities diversify their sources of funding and operate under new payment methods.*

The scope of work included financial management procedures for a potential private physicians group at Polyclinic No. 2. To support this effort, ZRP worked with the staff of Polyclinic No. 2, under Task 335 to begin the implementation of budgeting, cost accounting, and financial management for user fees. Specifically, under Task 333, ZRP was to work with a specific emphasis on putting in place, and testing appropriate and sustainable tools in management accounting, and internal cash and inventory control that are essential for implementing the privatization experiment (including user fees). These tools needed to be ready to be used when the private practice is officially launched (expected April 1, 1996). Appropriate polyclinic staff needed to be trained in these tools and be ready to implement them as organizational and legal authorizations allowed. The general management accounting needs of Polyclinic No.2 were also to be addressed.

1.2 Findings

1. *Developing a management accounting model for department level activity is feasible and useful in pragmatically guiding the allocation of resources and facilitating reform at an operational level*. Working at the departmental level revealed many legal, organizational, and financial obstacles that need to be overcome for meaningful reform. After identifying these obstacles, and facilitating their resolution, a management accounting model can be defined and is seen as particularly useful if instituted early-on in the entity's life.

2. *Careful attention should be paid to the where-with-all of the entity to maintain such information over time* with or without the assistance of computers. In addition, consideration should be given to the financial accounting (not just the management accounting) reporting requirements demanded of the staff. This means limiting the frequency and level of detail which can reasonably be maintained given the value of the decisions that are being made from the information. Even with computers, because the field of management accounting is new to users of the information, there is marginal value of producing "too much" detail early on in the effort. Considering the limitations of the financial accounting systems and other non-management accounting reporting

requirements, the paperwork load can be quite substantial and should be carefully evaluated before more detailed or complicated accounting procedures are implemented. In short, just because detailed cost and management information can be produced, does not necessarily balance with the cost or usefulness of such information. This does not mean, however, the users should not be trained in how to develop greater levels of detail. In these cases, experience in the field of management accounting is invaluable in balancing these issues.

3. *Focusing on the most important decisions to the local decision-makers is a facilitating method to demonstrate the value of management accounting.* Considering the findings defined above, attention was focused on those areas where improved levels of detail would hold significant value and interest to decision makers. Linking this with the management priorities of the institution increased the value of the model. For example, management had a great interest in incentive systems, and the allocation of workloads with their appropriate performance measurement. In many cases, due to the limitations of the financial accounting system, supporting detail was not available, but needed to be collected. The collection of this data was instituted and fed into a management accounting model. Data collection was expanded regarding not only the number of visits but the qualitative nature of the visits by level of service intensity. This provided tangible value and encourages the ongoing life of the management accounting model.

4. *Sound management accounting structures occur best when the entity in question has a clear mission, vision, and organizational structure*. Only when the purpose and structure remained clear to key decision makers was the use and role of management accounting maximized. While this may seem only natural to experienced managers who have had financial responsibility and accountability, this still needs to be identified to managers who have been operating in an environment of centralized command and control. Spending the time to clarify the mission of the entity and obtaining a consensus as to the expectations of key stakeholders is a sound investment in planning, particularly in new or "start-up" efforts such as this.

5. *Prior to the implementation of user fees and the supporting management accounting tools necessary to enhance such systems, it was found useful to expose emerging managers within the organization (60 days) to basic financial reports within their current operating conditions prior to any changes*. This points out the specific task at hand and the priorities, value, opportunities, and informational requirements that managers are legally and organizationally responsible to providing. This process is still ongoing at the Polyclinic.

6. *There is a tendency to tailor the organization to the known and available management and financial accounting systems and methods*. When implementing new methods of health care delivery such as through a private or free standing clinic, it is important to tailor, where possible, the accounting information systems to the entity rather than the other way around. Here, experienced management accounting skills are critical. Financial reporting requirements are not dictated by internal management. Rather, they are

externally imposed requirements on the management by regulatory authorities. As such, finding synergy between the financial and management accounting systems is essential to avoid duplication and enhance usefulness. For example, the cash-flow statement produced in the financial reporting schemes is acceptable for internal management *and* external requirements.

7. *There is a tendency to mix the success of the management accounting function with the success of the legal model.* No doubt, a revised legal status allowing complete autonomy of the department would clearly demonstrate a priority need to have management accounting information. None the less, the model and concepts of management accounting can and have already been observed in the facility (the Laboratory, the Director of Services, etc.) without a revised legal status. There are so many significant legal and other operating environmental challenges such as labor laws, unions, severe resource constraints, lack of medicines, etc., to link the success of management accounting with the obtaining a "legal" status would be inappropriate.

8. *The Financial Accounting Workshop when followed by moderate levels of technical assistance produced a clear synergy within the facility.* The attendance of the workshop by department level managers was as important, if not more important, than having "economic or accounting" managers, alone. Because there is an insufficient quantity of economic managers within many institutions, it was very appropriate to teach those managers most influenced by such techniques - the department managers. In the final analysis, management accounting is implemented among operational managers, not just accountants and economic directors.

1.3 Recommendations

1. *Nurture/facilitate the legal and administrative process and participants.* Legal and administrative obstacles during an environment of political and economic reform can be slow and require a substantial amount of intervention, nurturing, and process involvement. The timeframes for estimating such activities should be ample in duration and allow numerous opportunities for all stakeholders in the process to refine the issues. Competently providing for such a function in the immediate future (for 30–45 days) in this regard is seen as most useful. Specifically:

    - Finalize and obtain the City/Oblast decree. This means to help assemble whatever last minute documents, studies, or analysis that governmental authorities desire and obtain their consensus as to the expectations of the entity.
    - Get the new entity legally formed. At this writing, it seems the entity will be formed through a re-organization of an existing, but not operating, stock-holder corporation. This will greatly facilitate the process and minimize the new capitalization requirements of 1 billion koupons.
    - Submit/obtain application to the Ministry of Health for a License to Operate. A three year ongoing license is already attached to the entity that is being reorganized. (see above) There is a need to validate the authenticity of this license,

and insure transferability. The alternative would be to submit a new application for licensure which could take a number of weeks.

- Get the Agreement between the Polyclinic and the new entity signed

In addition, the last meeting with the City Health Administration (PM of March 6-1996) indicated the following needed to be provided:

- A sample City/Oblast Decree written by lawyers
- A definition as to what are the "legal consequences of invasive surgery" provided in a private setting
- Definition of legal "criteria" for measuring/monitoring medical quality and funding levels
- Definition of a legal framework for managing disputes *during* the life of the entity
- The assembly of a package of all of the above, and the obtaining of signatures/initials from the Oblast, City, Polyclinic, Surgeons, and the Lawyers.

2. *Monitor the financial and management accounting models* and encourage revisions to the management accounting model as decision-making needs change. Management accounting is a dynamic field and should be adjusted as decision-making needs evolve. Operational improvement, particularly in the early days of establishing a more autonomous entity, is expected to be quite rapid during the initial period. Thus, changes in the management accounting model should be expected and encouraged. Financial reporting requirements are regulated by local laws, therefore there is a need to insure compliance in this regard as well. Specific follow-up would include:
    - Insure this trip report is translated within a short period of time (two weeks) so entity managers can better coordinate their activities with ZRP staff
    - Verify the entity is providing monthly financial reports
    - Verify the entity is monitoring expected volumes, revenues, expenses, and cash requirements against actual levels.
    - Verify taxes and tax forms are being prepared and submitted as required.
    - Verify the written internal control policies and procedures are being followed, that spot audits by management are occurring, and that corrections are being followed.
    - Insure the performance indicators and essential planning and control mechanisms (budgets) are being followed as detailed in this trip report.

3. *Minimize the reporting requirements of the management accountant* and initially focus on work performance measurement and general cost and budget management. Given the management accounting model is not computerized within the facility, it is unrealistic to expect too many reports or "special" studies. Non-computerization will limit the ability for the management accounting model to grow to a meaningful degree after a one-year period. Until then, it is recommended to:

    - Encourage reports that reveal overall budget management and basic financial and cash management of the department as a whole.

- Encourage basic reports that reveal the productivity and efficiency of sub-specialties within the department (Urology, Oncology, Pediatrics, etc.).
- Avoid special reports that determine investment and divestment decisions at this time.
- Avoid too much attention during the first 90 days on the nature of costs (fixed and variable cost management) as well as what costs are direct or indirect. Rather, focus more on the management of essential inflow, use and outflow of funds, and the ability to predictably meet short term financial responsibilities such as payroll, medication funding, etc.

4. *If computers are going to be provided, they should be provided as soon as possible*. Providing such systems as the project ends does not provide for synergy between the technical assistance and competent skills of visiting experts, with the local staff trying to implement already new, and challenging issues. This will also help to insure the use of such systems are applied in the most appropriate areas. Specifically:

    - Identify if computers are to be provided- Insure surgery is on the target list.
    - If so, rapidly identify an implementation schedule for such
    - Coordinate the implementation of systems with technical assistance
    - Look for opportunities for periodic technical assistance to bring pragmatic and time-saving value via the use of such systems. This will more discernible value to the investment.

5. *Continue to revise and improve the procedure level costs seeking levels of detail that will support the performance management system as decision-making needs evolve.*. The cost objects in the department of surgery were expanded from 6 to 18. This required the recalculation of all department costs. To accomplish this, the costs of the sub-specialties found within the Department were broken into the three supporting levels of visits and procedures, Level I, Level II, and Level III, for each subspecialty. Each Level reflects a higher increment of resource use. This provided an improved cost basis to evaluate physician/clinical specialty financial and operational performance. Continuing this process as computerization and time allows, would only serve to enhance the model's flexibility. Specific emphasis should be placed on refining the RVUs so they are based as much as possible on observed data sets. (*the objective data* method as defined in the January 26, 1996 Management Accounting Manual—see Annex)

6. *Continue to include and encourage depreciation and other non-cash expenses as part of the operating expenses of managing the entity.* This provides for a more "full" cost picture of the respective cost objects and begins the process of getting managers to recognize the non-cash value of many of the subsidized costs being provided by state or other authorities. There is a tendency not to include expenses either because they are non-cash oriented or they are so severely constrained, they are currently not material. The model was built to accommodate all expenses.

7. *Maintain the experiment for about six months, and then quickly move to a more ongoing, and permanent model*. Do not let the "experiment" ramble with ill-defined goals and/or "moving" objectives. This will promote continued consensus as to expectations of all stakeholders and promote success. In addition, it seems clear the possible removal of excess employees will be needed to support substantial financial progress and more efficient ongoing operations. Specific goals for the first six months can be found in Section 3.4 of this document. Current overall objectives can be summarized as threefold:

    - Create a defined environment where managers have the empowered flexibility to allow resources to be used at optimum levels. Periodically meeting with the entity's management team by an experienced health care manager would facilitate this process and help identify points where recognition of ZRP objectives can be highlighted.
    - Create an environment where alternative sources of funding can not only be earned, but well managed. Monitoring cash flow statements would be an excellent method to follow progress in this area.
    - Create a political atmosphere where the experiment would be allowed not only to happen, but to continue. The privatization effort should go beyond "getting the agreements signed". Rather, the function of the effort should be continually nurtured and highlighted to key political, economic, and community stakeholders.

8. *Seek to obtain a "special legal status" for privatized medical practices minimizing the high capitalization requirements*. Effective March 1, 1996, new private enterprises are required to have 1 billion koupons of start-up capital and to be prepared to offer 2 billion koupons for closing the facility. Obtaining a waiver or minimizing such high costs would be a facilitating gesture in using privatization as a vehicle for reform. A possible alternative would be for newly emerging firms to reorganize existing entities not active in commercial activities. This was the approach currently being attempted in this field work.

9. *Seek to obtain a waiver of the VAT tax and other revenue based taxes (totaling 19.87%) for primary medical care offered in a private setting.* Current tax legislation taxes user fees at the gross revenue AND residual income after expenses at a 30-percent level. This totals nearly 50 percent of cash inflow can be taxed. Considering the extremely high salary-based taxes (an additional 51% of salary costs), and numerous other land, communal and depreciation taxes, tax relief would be useful! Because the government taxes at the top and bottom end of the funding sources of private firms, current tax rates tend to mitigate any real financial incentives. An alternative would be to waive the 30 percent income tax on residual income and maintain the revenue based taxes. When combined, both taxes undermine the possibility of generating surplus funds.

10. *Continue the training and education of managers*, particularly non-financial departmental managers in the role and techniques of management accounting. This is a very "empowering" step. Given the lack of trained economic personnel capable of supporting the many medical department managers, training department level medical managers is a

more realistic way of planting the seeds improved resource management. (See *Finding* #8, Section 1.3)

11. *Pursue additional "privatized" models outside of L'viv.* The model currently has "all of the eggs in one basket." Because the model requires the participation of policy-level decision-makers with operational level managers, this initiative is seen as particularly useful in facilitating reform and opening lines of communication as to how day to day improvements can be accomplished in a collaborative manner. One "bright star" might not be enough to fuel the fire. Additional sites would facilitate the effort.

12. *Follow-up and consult with Oblast (L'viv Regional State Administration) operational audit group, specifically Pavel Tertuchnyi and his staff*, to determine what current Ukrainian decrees/policies/internal control requirements might influence any of the *ZdravReform* projects occurring or being considered in L'viv. This department has audit authority of health care institutions in the area and, therefore, can reveal the legal and operational rules and regulations which IDS sites need to observe, seek exception to, and/or modify in order to remain within the current legal framework of the Ukraine. Proactive consultations would facilitate field progress and program design. Specifically:

    - Build a cooperative bridge between ZRP and the oversight arm of the health care sector.
    - Request their input as to proposed reforms/IDS activities and the current regulations
    - Get in the loop on the creation of new internal control policies at the Oblast level that might effect reform.

13. *Initiate a more widespread review of common (lower-level) internal and operational control regulations currently being required of health care organizations by Oblast level decrees and other governmental authorities, and, in light of desired economic incentives for reform, formulate recommendations for their prioritized revision.* It is recognized that establishing a prioritized list of the most useful and pragmatic policy reforms that can be rapidly be accomplished while providing a substantial and immediate benefit to the health care providers is difficult. By surveying current internal control being required of health providers at a regional and local level, it would be much easier to establish a "targeted" list of lower level policy reforms that would enhance the day to day flexibility and management of providers. For example, internal control regulations for cash management are quickly becoming excessively restrictive. Unless this is placed under control, larger scale policy reform can be bureaucratically mitigated.

14. *Follow-up with the Director of Services at the Polyclinic and assist her in applying management accounting principles to the management of the facility-wide "sick-list" function.* The Director attended the Management Accounting Workshop (Wouters/Else) and is seeking to apply the principles of cost and management accounting in order to streamline the excessive resources being consumed by the sick-list function. To accomplish this, ZRP staff performed an 80/20 analysis on the high volume-high cost

medical conditions. Then, initially focusing on back-pain patients, the Director is trying to implement reform on three levels:

- Increased emphasis on preventative management
- Improved process and path of treatment management
- Improved patient follow-up and tracking

To facilitate this reform, the Director has been provided the AHCPR (Agency for Health Care Policy and Research) guideline on the Treatment of Low Back Pain (Guide #14) and has received a detailed overview of the process and management accounting support that can facilitate the effort.

1.4 Overview of Field Activities

The field activities were divided into four areas. First, an assessment of the legal, organizational, financial, and management environment and requirements was made. This was a useful step in uncovering the realities of day to day health care regulations and requirements in the region. Second, collection of the reporting requirements of the key financial systems was prepared for both public and private entities. This was a necessary step for financial management and a useful step in creating complementary reports in the management accounting model. Third, a cooperative design of the management accounting system was developed. Fourth, the continual and constant facilitating of legal and administrative issues key to this project including, decrees, authorizations, meetings, and other such coordinating activity. A daily log of field activities can be found in the Annex to this document.

2. Legal Model

2.1 Governmental Authorization

Privatization of a public facility requires an authorization from the governing authorities. The authorization provides the right for such an experiment to be conducted (and continue) as well as facilitating the legal, operational, and economic framework that is required for such an effort to be successful. This can include a number of "waivers", "exceptions to the rule(s)", and other such "permissions" in order to realize the benefits of such an effort. For example, the ability of a private clinic to be granted the use of public facilities and equipment.

The decree from the governing authorities being sought includes a number of issues seen as crucial in order to provide the stakeholders of the experiment with a sufficient level of empowerment while not exposing them to legal or political risk. These included:

- A statement defining the experiment and an authorization allowing the experiment to occur for a given period of time.

- Authorization, if successful, for the experiment to continue after the initial period of experimentation.

- The authorization for the new "privatized" entity to receive sums of money for the treatment of public patients.

- The job protection and relocation/re-assignment of employees deemed "not necessary" prior to the permanent privatization (should it be successful) at the close of the experiment.

- The authorization to collect user fees in a public institutions normally providing "free care".

- The authorization for the use of facilities, including normal equipment on the part of a private clinic operating in a public institution.

As of this writing, such a decree has not been provided by Oblast or City level authorities and is a major function of post Task 333 follow-up. (See Recommendation #1, Section 1.3)

2.2 Definition of a Legal Entity

In addition to a governmental decree of authorization, it was necessary to create a separate legal (private) entity. Before a legal entity can be formed and prior to the significant contribution of capital required to do such, the stakeholders in the department of surgery would like to have the decree defined in Section 2.1 above. None the less, the entity was outlined and organized, short of the filing of legal papers. An alternative to the creation of a new entity is the reorganization (purchase) of an "old"—existing entity that is currently not

active. One such "old yet inactive" entity was located and this alternative was seen from a legal perspective as a likely and expeditious method to establish the new firm. The following describes the form and nature of the desired legal entity, whether created or reorganized (bought).

The preferable form of the new legal entity was seen as a stock-company where shares are issued to founding members after an appropriate contribution of capital. In this case, capital contributions for a newly created entity were significant requiring a total of 1 billion koupons (approx. $5250 USD) of start-up capital. Two billion koupons are required to dissolve such a entity. A normal and rather traditional set of bylaws were established thorough the assistance of a local lawyer and are attached in the Annex to this document. In addition, the ownership and organizational charts found in the Annex to this document illustrate the ownership authority of the entity. Note, there are two centers of responsibility authorized by the founding members (stockholders): The Board of Directors and the Audit Committee. The Board reports to the stockholders and votes to select the Head of the Department. In this case, the Head of the Department was also to be the Chairman of the Board of Directors. The Head of the Department, in collaboration and approval of the Board, would select an Economic Director and a 1st Deputy known as the Medical Director.

The Audit Committee also reports directly to the stockholders and acts as an independent function from the Management structure. The purpose of the Audit Committee is to insure the Management structure is functioning as designed and performing as expected. This two-authority approach seeks to provide adequate safeguards to the stockholders and independent appraisal of the management. In short, a self-governing and controlling entity.

2.3 An Agreement Between the Polyclinic and the Private Entity

A legal agreement of cooperation between the private entity and the Polyclinic detailing the cooperation requirements, the procedures for cooperation, the responsibilities of each party and a few additional matters was also developed. The legal agreement was designed to be signed by the agreeing parties, was produced through a number of meetings between the lawyers, the future stockholders of the private company and the polyclinic, as well as members from the ZRP team. The agreement is currently in the hands of the Head of the Polyclinic and is being finalized. The major points and issues found within the document included:

- A statement of agreement defining the parties involved in the agreement. In this case, the parties were the newly formed "company" and the Polyclinic.

- A statement indicating the subject matter of the agreement indicating that the parties sought to cooperate in sharing physical resources for the provision of free and user-fee medical services, that the cooperation was limited to the surgical department, and that the cooperation would begin on April 1, 1996.

- A series of statements indicating what each party would contribute to the experiment. In the case of the Polyclinic, they would grant the use of and access to existing facility space and equipment (not ownership) currently being occupied by the surgery department, that they, the Polyclinic, would transfer funds on a monthly basis sufficient to cover the clinics responsibilities to provide the defined benefit package of free care to the catchment area including funds for salary, medication, and other smaller operating expenses, and that shared infrastructure services such as utilities and normal building maintenance would be provided. Equally, the newly formed company would provide suitably qualified personnel and management, medications appropriate to the funding amounts, and supporting services necessary to meet the clinics obligations for continuing the levels of care. Joint capital projects would be shared by both parties.

- The procedures for performing the joint activity between the parties included the taking of equipment inventories prior to the start of the experiment, the determination and monitoring of mutually acceptable levels/amounts of free health care provided by the private clinic, the establishment of a mutually agreed level of medication provisions given the funding levels by the Polyclinic, the hours of service and operation, the mutual agreement of which services might be provided by user fees, the terms and frequency of the Polyclinics remittance of funds to the private clinic, and the reporting and sharing (percentage) of any residual profits after taxes.

- Should the experiment fail to be mutually successful, all properties granted shall be returned to their owners.

2.3 License to Operate

The Ministry of Public Health (MPH) requires a *License to Operate* from all entities delivering health care services. Licenses are issued by the Ministry for periods of up to three years. The license application, review process, and resulting approvals are managed by a 10–12 person committee which typically meets once per month in Kiev.

Currently, the procedure involves five steps.

- First, the person or individual representing a private or public entity submits a request to acquire a license on the entity's stationary.

- Second, notarized copies of the founding entity's registration documents indicating they are a legal entity are submitted to the application committee.

- Third, an exact list of the types of medical activities that are planned is provided to the MPH

- Fourth, the receipt of a written authorization from the local public health administration

- Fifth, a license fee payment is submitted via a bank transfer. The current fee is 10200000 koupons, or about $55 at this writing.

Examples of this process, supporting applications, and fee receipts can be found in an Annex to this document. The process defined above was current as of this writing and is, naturally, subject to change.

2.4 Employee Contracts and Other Documentation

Employee contracts between the newly formed private entity and their employees needed to be created. The employee contracts or written labor agreements needed to include the following mandatory elements:

- Employee requisites (name, birth date, permanent address and passport data)
- Name of position
- General terms of the contract (definitions of parties, scope, etc.)
- List of responsibilities
- List of qualifications
- List of entrusted equipment
- Working schedule(s) including a definition of work days, work hours, total days on duty, days and holidays off, etc.
- Payroll procedures
- Types of fining and disciplinary actions
- Procedures for lay-offs, dismissals
- Procedures for financial responsibility (breakage etc.)
- Any pay for performance conditions, incentives, or clauses.

Of some importance is the job description, responsibilities, and duties. Selected job descriptions were produced in Ukrainian and can be found in the Annex of this document. Other supporting legal documents consisted of employee and labor laws regulated by the government. A copy of relevant laws can be found in the Annex, as well.

3. Organizational Model

3.1 Overview

The entity defined in the previous section is directed at achieving specific goals within a structured system of functional activity. It is not unusual for such organizations to have a number of goals and for those goals to shift in nature and scope over time. This is particularly the case where an organization is seeking to do something different as is the case in this model. It was therefore important to carefully define initial goals and outline the overall statement of purpose of such an organization early on in the development of the entity. Initial goals were selected based on the desire to be pragmatic as to what can be achieved. In addition, the goals needed to be defined with tangible evidence (benchmarks) of achievement. Careful goal definition allowed for greater cohesion among the participants and interested parties as they organized and implemented the necessary functional activities of the entity.

The following sections summarizes the organizational development work that was accomplished during the task. First, the mission statement, or the statement of purpose of the entity was defined. The function of the mission statement was to clearly define the general purpose of the entity. Second, a vision statement was developed allowing the ongoing mission of the entity to be directed toward a common vision of the future. The vision statement is useful in helping to maintain the course and direction of an organization over time. This was seen as particularly useful for a new organization operating in "uncharterted waters". Third, a listing of pragmatic goals were drawn up. These goals are necessary in order to make the mission an operating reality The goals represent about six months of activity and might require moderate revision over time. The purpose of the goals, along with their measurable criteria for achievement, was to guide management decision making during the coming year and provide tangible criteria of performance evaluation.

3.2 Mission Statement

> "The mission of the Surgery Department is to be recognized as providing improved quality of surgical and ancillary health care services to patients while promoting cost efficient yet effective care. It is also our mission to provide such services in a compassionate and caring manner where the care we provide is centered around the well-being of the patient, the family, and the community."

3.3 Vision Statement

> "The vision of the Surgery Department is to provide an ongoing model of efficient and effective medical excellence for the Ukraine. Specifically, the Department seeks to demonstrate a model for outpatient Surgical and Ancillary Services for other providers of medical care to follow."

3.4 **Goals**

The following goals were defined for the Department. Many of these goals have already been achieved. These goals were viewed as broad, yet strategically critical for declaring the model successful. Goals 1 and 2 were defined to be achieved prior to the "official start" date. Goal 3 and 4 are to occur during the first months of operation. In addition to these goals, it is the intent of the manager to define additional and rather specific goals during the operating year. These more specific goals will be cooperatively defined among the organizational staff led by the management and shall be directed at strategic, administrative, operational, financial, and medical functions.

Goal 1: Establish the Surgical Department as a legal self-managed clinic.

Measurable Criteria:

- The obtaining of a decree from governmental authorities (Oblast/City) authorizing such an experimental management model/entity to be conducted within the confines of a public institution.
- The establishment of a legal, separate entity operating within a public institution and recognized under the laws of the Ukraine.
- Obtaining a License to operate and deliver medical services from the Ministry of Health
- A signed agreement of cooperation between the Entity and the Polyclinic.

Goal 2: The establishment of the necessary internal organizational, financial, medical, and supporting operational policies and procedures necessary to support ongoing management of the entity.

Measurable Criteria:

- The documented organizational framework for managing the entity including:
    - An organizational chart
    - Functional job descriptions
    - Reporting and authority definitions
    - The establishment and submission of quarterly financial accounting reports sufficient to serve the legal requirements of the external reporting and taxation requirements.
    - The establishment of a management accounting system sufficient to support essential pricing, resource management, and basic productivity analysis.
    - The establishment of an internal control system for basic balance sheet management including cash, medications, and equipment.
    - The establishment of a human resource management policy particularly including the formulation of salary, incentive, and performance criteria.
- The hiring of a bookkeeper
- The documented framework ongoing quality assurance of medical services

Goal 3: Establish a management and organizational structure that is responsible, yet accountable, for the efficient and effective use of its resources for the care of the targeted patient population. This means to improve the efficiency and effectiveness of health care delivery regardless of whether the services are free or charged with user fees.

Measurable Criteria

- Establish the leadership function within the organization including the definition and appointment of an executive and managing staff (Managing Director, Medical Director, Chief Economist) as swell as an internal audit function which is independent of the executive management.
- Implement the phased-in incentive and performance management model as defined in Section 3.6.
- Documented framework for evaluation of efficiency and effectiveness including key performance reporting of all service levels of health care delivery. - Done

Goal 4: Obtaining user fees generated from selected medical services provided by the entity and hone internal control policies and procedures.

Measurable Criteria

- The definition of a service list with prices
- The receipt of cash
- The payment of taxes
- Remit funds to the Polyclinic

3.5 **Organizational Structure**

There is no one fixed structure for organizations. Each organization should accommodate the structure it selects based on the mission, resources, and services it seeks to provide. The organizational structure in this field work needed to reflect the nature of the services being provided, those being labor intensive services where the qualitative nature of the labor was of paramount importance to service outcomes. Thus, direct lines of responsibility and resulting accountability were sought where, given the high levels of professional responsibility found among staff physicians, as much decentralization of labor control and accountability was encouraged. For example, office nurses are to be the responsibility of the office physicians. Physicians were accountable for the nurses activities. Additionally, facility management was a cross-organizational issue and included operating room management, scheduling, and maintenance as well as the supporting surgical equipment maintenance, medicine and medical supply controls, and general clinic maintenance. Here, a defined center of responsibility was established under the primary control of the First Deputy. The organizational chart shown on the following page illustrates the structure.

Insert one page organizational chart

See Microsoft Powerpoint Chart: taras.ppt

3.6 Incentive and Performance Management System

Transitioning current operating realities to a new mission and vision of management was a primary role of the incentive and performance management system. Rather than creating a single system, it became apparent a number of incentives, provided in an orderly sequence needed to exist. Thus, the incentive "system' became an incentive "process" that will change over time.

A three-phased incentive system for physician payments has been designed and shall be implemented during the first six months of the entity's life. The phased approach reflects management's initial focus on some fundamental concerns, and, once these are resolved, to rapidly migrate toward more refined measures of linking pay with medical performance. In short, management believes there is a necessary sequence to building an effective organization. The role of the incentive system was to support this process. Likewise, the role of the management accounting model was to monitor this effort.

Phase I is expected to last 1 to 2 months and shall focus on the work time and attendance of physicians. Time and attendance management, which is a current operational problem and is seen as an important issue to resolve before more refined incentives can be implemented, will be accomplished through the introduction of a regulated attendance monitoring system supervised within the newly formed entity. Base pay will be set on a defined minimum number of hours and days for each physician in coordination with the Polyclinic's operating schedules. Phase II, occurring in months 3 and 4, will expand the incentive system to link payments to the complexity (intensity) of the services. In addition to meeting gross volume goals of services based on patient visits, there was a desire to reward those physicians who deliver medical services whose intensity of service is above the level of a normal "office visit". The intensity of services will be defined by a three-level classification system, with each class reflecting a higher level of intensity and the resulting payment based on a relative point system. Phase III will continue this process with a tighter control on quality and effectiveness and efficiency within each level of service Quality definition and measurement will be accomplished on a committee peer review process. The peer review process is intended to build consensus among the medical staff as to the measures and processes in which quality can be defined including the appropriateness of care and referral patterns. The phases are summarized in the Annex to this document.

4. Management Accounting Model

While there are many types of accounting systems, managerial accounting is rooted in some basic principles that are different than financial, tax, or other types of accounting. In this regard, management accounting at Polyclinic No. 2 was primarily designed to:

- Provide information to individuals within the organization. As such, the reports format, their content, and their timing were defined as the managers wished under the guidance of the ZRP team.

- Generate special and unique reports tailored to specific decision-making needs which may change over time. This is unlike tax or financial reporting requirements which normally require a repetitive reports for repetitive issues such as calculating taxable income or identifying and accounting for assets. Minimal priority was, however, given to the design of "special reports" during this field work.

- Report on the past and outline the future. A primary purpose of management accounting techniques applied in the filed was to appropriately guide managers and their decision-making needs regarding decisions which influenced the future. (This is quite different than most financial accounting reports which are geared toward measuring and identifying only what has occurred in the past.) In this case, two major outcomes of the field work were:

    1. The ability to appropriate the funding (revenue) budget (both state funded and user fees) among responsibility centers within the privatized department based on costs, and,

    2. The ability to allocate expenses among the responsibility centers and report variances to expected values as volumes/actual performance varied from expected levels.

- Have no externally imposed guidelines or laws. The management accountant was free to use his/her best judgment, design special reports, and make assumptions as he/she saw fit in cooperation with the host management. This was unlike financial accounting systems which are governed by strict reporting laws and procedures. As such, management accounting reports and procedures applied subjective data. The ability to incorporate such data was useful as managers must include such information in their qualitative decision-making over evaluating past performance, day to day operational management, and guiding their organizations into the future. The exception to this issue was in the application of internal control guidelines. Here, local laws and regulations needed to be coordinated with other principles and practices of sound management.

The following illustrates management accounting tools developed for the emerging privatized entity within Polyclinic No. 2.

Management Accounting Tools Used in the Entity
Budgeting: The budget takes the goals and objectives of the health care organization and states them in measurable monetary form. The budget acts as a financial plan. There are several types of budgets including a revenue budget, expense budget, operating budget, cash budget and capital budget. **Cost accounting: Cost accounting describes the performance of the entity in terms of the cost implications of the services it delivers. These tools enables one to examine the costs of services in terms of efficiency, pricing and profitability.** **Internal Control: These are methods and measures to safeguard assets, seek accuracy, and reliability of accounting and administrative controls, and promote operational efficiency. C a key asset. Cash management includes the steps and procedural aspects of efficient and effective management and control of cash payments, such as those from user fees.**

The management accounting model in the newly emerging department at Polyclinic No. 2 was targeted to be used in a number of decision-making areas. In a prioritized sequence, these decision-making areas are shown below. How frequently these decision-making areas were seen to be applicable during the first six months of the entity's life span is shown parenthetically.

- (80%) Planning and control—including demand assessment, budget planning, variance analysis from budget forecasts, and the analysis of costs considering changes in volumes or changes in targeted expense management goals. This application of management accounting is discussed in section 4.1 below.

- (15%) Pricing—including an understanding of the fixed and variable nature of costs, how costs can influence pricing decisions, as well as the overall optimization of pricing systems and policy so as to maximize surpluses. This area of management accounting is covered in section 4.2 below.

- (5%) Evaluation of alternatives—including decisions as to whether to invest or divest into projects, programs, facilities, and more. In short, by having an understanding of underlying costs and the nature of those costs, more objective decisions can be made in regard to the application of limited financial resources. This area of management accounting is also covered in section 4.2 below.

4.1 Planning and Control

Three areas of planning and control were seen as pragmatic applications for a management accounting system at the entity and would be involved in 80% of the management accounting model's initial use. These areas were defined as:

- Demand assessment
- Budget planning and preparation
- Variance analysis from budget forecasts and general key performance reporting

Demand Assessment

The assessment of the demand of patient service for the facility is traditionally a function of a marketing department in many western-style hospitals and clinics. In this situation, the entity needed to have an internal capacity to monitor demand levels. Further, this capability needed to be realistic considering the complete lack of computerization, the minimal availability of updated statistics, and the availability of qualified personnel to maintain such information over time. The value of such demand information was seen as a method to promote more fundamental applications of management accounting such as budgeting and strategic forecasting. Therefore, the need to flexibly incorporate the function of overall demand assessment of services into the management accounting purview became necessary.

Demand assessment is tasked with the determination of the level and types of services that are to be required to be provided by the entity. This task is a particularly important step in that the privatized entity operating within the public clinic is to be responsible for determining and managing their catchment area for offering "free" services. In addition, the information is useful to evaluate potential new services such as special fee-for service activities offered above the standardized portfolio of free medical care. In the final analysis, reports based on the assessment of demand can be provided to management for such fundamental decisions as estimating the need for physicians by specialty. An example of such a report is shown below and is an outcome of demand assessment.

Specialty	***Demand (No. of Drs.)***	***Supply (No. of Drs.)***	***Overage (No. of Drs.)***	***Shortage (No. of Drs.)***
Surgery	4	5	1	-
Trauma	2	3	1	-
Urology	1	2	1	-
Proctology	1	2	1	-
Pediatrics	3	5	2	-
Anesthesiology	2	4	2	-
Oncology	2	1	-	1
TOTAL	***15***	***22***	***8***	***1***

The methodology of demand assessment selected for this situation was adopted and adjusted based on a health planing model developed by the Division of Planning of the American Hospital Association. The methodology was composed of three steps:

- Step 1: Define the service area and estimated population in the area using targeted services
- Step 2: Evaluate the current year service demand
- Step 3: Develop scenarios of forecasted service demand

Step 1: Define the service area and estimated population in the area. In the case of Polyclinic No. 2, a defined service area existed as well as supporting service estimates. The polyclinic serves 124,000 people in the Frankivskt Rayon of L'viv City.

It should be noted that when user fee services are offered, the defined service area (the total possible catchment area) may unofficially enlarge for these fee-for service offerings. As such, the official Oblast/City service area might need to be dynamically redefined by internal management for such "paid-for" services so as to promote improved management planning and budgeting decisions as these services grow. Three methods for the internal management of the entity to enlarge (or adjust/redefine) the official Oblast defined service area was suggested: The geographical origin approach, the time to travel approach, and the market-share approach.

The geographical origin approach required the collection of data on the exact location of the patient so a determination at a later date can be made as to the pattern and geographical distribution of patients outside of the official Oblast catchment area. Using this method, budget forecasts later can be produced based on defined service offerings being utilized by patients outside of the current service area. An example of such an analysis would be:

Service Area	*No. of Visits to Clinic*	*Percent of Total (%)*
Current	55000	**.**96
Oblast B/ or neighborhood x	500	**.**009
Oblast C/ or neighborhood y	1600	**.**03
Oblast D/ or neighborhood z	100	**.**001
TOTAL	***57200***	***100%***

The time to travel approach functions in a similar method to the geographical origin approach. Rather than defining the population based on specific geographical origin such as Oblast, postal code, or neighborhood, the entity would need to collect the time it takes for patients to get to the clinic. The advantage of this method is it tends to illustrate how willing patients are prepared to travel for services. As the services become more unique or specialized, the willingness to travel generally increases. For decisions to expand services outside of the confines of the facility, this type of approach was quite practical and recommended for the situation. An example might look as follows:

Service Area	*% < 5 Kilometers*	*%>5<10 Kilometers*	*% . 10 Kilometers*
Surgery	95%	4%	1%
Trauma	96%	4%	0%
Urology	93%	6%	1%
Oncology	89%	7%	4%
etc.	**etc.**	**etc.**	**etc.**

The third approach, based on a definition of market share was seen as beyond the scope of the operating realities of the entity. The challenge of collecting enough accurate statistics on competitors as well as total service demand was seen as more of an exercise in the theoretical

rather than the practical for this situation at this time. In addition, given the entity is primarily operating in a "free-for service" approach, as opposed to "fee for service", it was felt a market share study would not provide enough meaningful management information to make the basic types of strategic decisions needed over the next few years.

Step 2: Evaluating the current year demand

Prior to an estimation of forecasted demand for services, it is necessary to collect and evaluate the current year demand for services. Evaluating the current year demand can be summarized as a series of substeps starting with the collection/obtaining the service area population estimates from Step #1. A summary of the substeps required to evaluate the current year demand is presented below with each step numbered from 2.1 to 2.7.

X =

/ =

_ =

Substep 2.2 can be determined two ways. First, the "official" rates published by in the 1960s can be used as defined by authorities of the former Soviet Union. These rates, however, have not been updated and are often seen as "questionable" by many physicians in that they do not account for changes in technology, medicines, treatment patterns, etc. It should be noted, however, these rates established in the 1960s were apparently based on "sound" studies. A (second) practical alternative was to manually adjust the 1960's usage rates based on a consensus of the management. In all cases, the usage rates are estimates of the actual demand for services by the catchment population. When the population area (substep 2.1) is multiplied times the physician use-rates (substep 2.2), the management accountant obtains the theoretical number of physicians visits required to serve a given population.

Substep 2.4 can be determined by taking the actual number of visits for each physician specialty divided by the total number of physicians within each specialty. When substep 2.4 is divided into substep 2.3, the management accountant can determine the total number of physicians currently being required to meet the service demands of the population catchment

area. This amount of physicians is being calculated on the current levels of productivity, not what may or may be possible through productivity improvements. When substep 2.5 is reduced by the actual number of physicians currently employed, the management accountant can determine the under or over supply of physicians within the entity by specialty.

Step 3: Developing scenarios of forecasted service demand

By adjusting the actual productivity levels determined in step 2.4 above with the productivity benchmarks of more efficient and effective physicians, the manager can better determine the number of physicians that are, in fact, over supplied given the current demand for services and the desire to weed-out unproductive labor. When this adjustment is accomplished each year, targeted (goal) productivity levels can be measured and monitored for each physician and/or area of specialty. These measures represent useful (gross) measures of efficiency and productivity were seen as accomplishable in a non-computerized environment.

As indicated early, an underlying assumption of this demand assessment was the calculation of the population demand for services (substep 2.2). Given the depressed economic situation, changing health care policy, and other variables, the demand for services might be influenced. As such, it was seen s important to periodically evaluate the physician use rates (substep 2.2) as well as the population catchment area (substep 2.1).

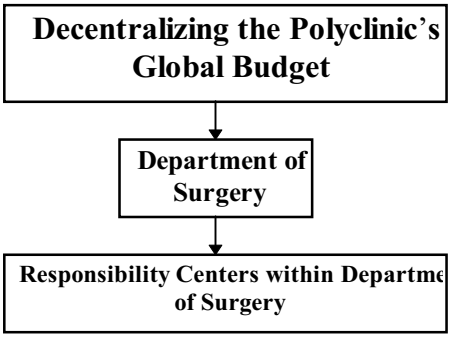
Finally, demand assessment allows for a initial translation of generalized entity mission and vision statements into pragmatic goals and objectives of operating reality. Additionally, demand assessment provides gross measures/indicators for the definition of services, their demand, and the wherewith all of the entity to meet that demand. Based, in part on this assessment, more detailed budget planning can then be performed.

Budget Planning and Assessment

Budget planning is a major area of interest and concern for the management accounting function. The budget planning process can be described as the formulation of an operational plan based on the mission of the organization and the translation of that plan into a meaningful statistical, revenue, expense, and cash budgets which will support ongoing management decision making within the organization. A key feature of budgets is the ability of the budget reporting systems to provide management with key indicators, measurements, variances, and performance evaluations as to how the plan is proceeding and if any corrections or adjustments to the plan or operating conditions need to be made. Needless to say, the budget serves as a primary communication tool regarding operational performance. In this case, the budget planning and performance process was primarily seen as the definition of an operating guide and basic performance/variance reporting system. It is the intent of the budget performance system to inform managers at various levels of the organization as to how their specific areas of responsibility are progression over the lifespan of the budget period.

In order to implement a meaningful budgeting process, the following areas needed to be defined:

- A clear organizational structure defining areas of responsibility, reporting and accountability hierarchies. (Refer to Section 3.5 of this document). This meant decentralizing budgetary responsibility as shown in the following diagram.



Due to the small size of the clinic, it was not seen as necessary to provide each specialty area within the department with a separate line-item budget. Rather, the decision was taken to provide each specialty are (Surgery, Urology, Proctology, etc.) with a small package of periodic reports highlighting important budgetary variances, most of which focused on volumes, labor productivity, and medical supply usage.

- A financial accounting system capable of collecting, recording, and reporting essential financial and statistical information necessary to support a management accounting system. In this case, legal regulations limited the financial accounting system to the standardized chart of accounts as defined by the government. (18 articles with their appropriate sub accounts) While these accounts were somewhat generalized, they provided adequate financial visibility to make appropriate allocations to more detailed responsibility centers within the entity such as the physician specialty areas. This process was accomplished and detailed in Task 335.

- The collection of historical financial and volume statistics of the entity so that historical trends could be used to help forecast future activities. This is particularly important for determining productivity levels and cost behavior as volumes fluctuated. This process was accomplished and detailed in Task 335 and expanded in Task 333.

- The definition of a specific individual to be assume primary budget formulation and coordination responsibility. The position has been offered to an individual and as of this writing, the individual has not provided final acceptance to the offer.

- The definition as to whether the budget methodology will be a fixed budget, flexible, service line or some other variation. In this case, the budget was initially planned to be a fixed budget with the intent to migrate to a flexible budget as budgetary expertise grew. A summary of the considerations for such a decision is shown on the following page.

Considerations Used I Selecting a Budget Methodology

Budget Method	Advantages	Disadvantages
Fixed Budgets	-**Traditional, well-known approach**; -**Simple to understand**; -**Less time consuming**; -**Appropriate when volume is stable.**	-**Link between cost and volume is not well defined**; -**Budgets cannot be revised easily if future volume changes**; -**Cannot link budget performance to changes in volume, unit costs, prices o productivity.**
Flexible Budgets	-**Budget amounts reflect changes in volume**; -**Differences between planned and actual budgets can be explained in terms of changes in volume, unit costs, prices, and productivity**; -**Refinement of information for developing flexible budgets will improve future budgeting efforts.**	-**Time consuming**; -**Substantial training in budget techniques necessary**; -**Requires fairly sophisticated information system linking patient records, inventory records, and financial information.**
Product Line Budgets	-**If used in conjunction with flexible budgeting, the same advantages cited above are true**; -**Shows the effect of groups of services on volume, staffing and profitability**; -**Volume projections based on product lines are often more accurate.**	-**Time consuming**; -**Requires substantial effort to develop resource consumption profiles by patient group**; -**Requires sophisticated information system linking patient records, inventory records and financial information by patient group**; -**Requires coding system which can track patients by patient groups**; -**Responsibility centers may not necessarily align easily with product line budgets.**

Four budgets were targeted to be modeled in the fieldwork:

- A statistical budget
- A revenue budget
- An expense budget
- A cash budget

A fifth budget, the capital budget is to be produced as a surplus of funds became available. At this writing, resource constraints prevented even the consideration of a capital budget.

An example of the one year statistical budget format appears as follows. The basis for all statistical budgets were based 3 year historical trends. The statistical budget was formulated by the department stakeholders after receiving technical assistance in methods and considerations. Level I, II, and III as shown below represent various levels of intensity of the volume statistic (visits and surgical procedures). An explanation of these levels can be found in the Annex. The format shown below was used for each of the surgical specialties. Here, urology is shown.

1996 **Free Services**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Etc.**
Urology								
Level I								
Level II								
Level III								
TOTAL	*a*	*a*	*a*	*a*	*a*	*a*	*a*	*a*
1996 **User-Fee Services**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Etc.**
Urology								
Level I								
Level II								
Level III								
TOTAL	*b*	*b*	*b*	*b*	*b*	*b*	*b*	*b*
Grand TOTAL	*a + b*	*a + b*	*a + b*	*a + b*	*a + b*	*a + b*	*a + b*	*a + b*

In addition to the above statistical budget, supporting statistical budgets including employee and staffing FTE budgets, equipment usage, and outside referrals is to be maintained. These supporting statistical budgets reflect objective data regarding the use of key resources of the department.

The revenue budget was slightly more challenging. The source of the revenue will primarily be (98%) a periodic lump sum of funding from public funds. In addition, there is an expected small supplement of user fee revenues. The challenge was to initially allocate this revenue for budgetary performance monitoring purposes among the various responsibility centers within the entity. In this case, six (6) areas of revenue responsibility were identified, each with three levels of service. A total of 18 revenue centers were established including:

- Surgery x 3
- Trauma x 3
- Urology x 3
- Proctology x 3
- Pediatrics x 3
- Oncology x 3

The administration and organizational management centers were not viewed as being a revenue center. Based on the cost methods of services provided within each service area, (Obtained in Task 335) the revenue was allocated accordingly. Finally, based on the statistical volume budget, revenue is to be allocated to each month for each specialty according to the volume forecasts. At the end of each period, computations can be made as to the under/overage of revenue for each specialty area when compared to the budgeted forecasted amounts. The rapid creation of historical revenue trends, based on, in fact, a capitated funding amount, was seen as useful for establishing a track record of revenue per volume for ongoing capitation management. By refining the statistical budget over time and honing the costs of the supporting services to the intensity level (Level I, II, and III), improved capitated revenue management was possible. Until some historical basis for capitated management could be established, supplemental revenue obtained through user fees plays an important role in equalizing any initial misapplications.

The revenue budget format for each subspecialty appears as follows where x = volume forecast from the statistical budget times allocated revenue.

	Urology	**Revenue**	**Budget**	**Format-**		***1996***
Free Services	**April**	**May**	**June**	**July**	**August**	**etc.**
Level I	x	x	x	x	x	
Level II	x	x	x	x	x	
Level III	x	x	x	x	x	
TOTAL	*a*	*a*	*a*	*a*	*a*	
Fee for Service	**April**	**May**	**June**	**July**	**August**	**etc.**
Level I	x	x	x	x	x	
Level II	x	x	x	x	x	
Level III	x	x	x	x	x	
TOTAL	*b*	*b*	*b*	*b*	*b*	
Grand TOTAL	*a + b*	*a + b*	*a + b*	*a + b*	*a + b*	

The expense budget was produced in a similar manner. In addition, the expense budget is also required to be maintained in the financial accounting system as a line-item budget. To avoid duplication, and take advantage of the current, and regulated, financial reporting requirements, it was felt the financial reporting system was sufficient to support line item management as well as cash flow management.

Clearly, the allocated expense budget based on costs was seen and demonstrated to be an excellent tool to allocated capitated amounts within the department and providing for the opportunity to calculate a flexible budget. The lack of computers and automated communication devices almost precludes the computation of periodic (monthly) expense budgets for each sub-specialty. None the less, a detailed entity-wide expense budget broken down by each specialty and level of intensity within each specialty, provided valuable and pragmatic detail for decision making. The specific areas where this proved useful were:

1. Determining if funded amounts were in line with historical operating reality
2. Scenario-playing (what-if) changes in volume
3. Evaluation of alternative funding scenarios
4. Evaluation of the impact of user fees as an augmentation to state funded amounts
5. Scenario-playing (what-if) different cost assumptions including changes in the fixed and variable splits of costs.
6. Determination of financial performance within each area, particularly considering changes in volume

The line item expense budget developed in the financial accounting system is shown below. In the Annex, a complete financial reporting format is resented as regulated by governmental authorities.

Fixed	*Financial*	*Expense*	*Budget*	*1996*	
	January	**February**	**March**	**April**	**etc.**
Doctors					
Nurses					
Aides					
Sub Total					
Benefits					
Total Salary					
Ed Supply					
Drug Supply					
Other Supply					
Total Supply					
Equip/ Repair					
Depreciation					
Total Equip					
etc.					
etc.					

The cash budget is required to be produced in the financial reporting documentation. Thus, an additional management accounting cash-flow statement was not seen as necessary given the already burdensome volume of paperwork being required of the managers. The cash-budget concept can be described as follows. Polyclinic practice provides the cash budget to be shown by sub-account detail.

Example of Cash Budget Format				
Item	***Month 1***	***Month 2***	***Month 3***	***etc.***
Govt funds collected for service operations	900,000	980,000	1,050,000	
Other cash receipts (sale of assets, gifts,)	60,000	540,000	40,000	
User fees & other contracts	30,000	20,000	50,000	
TOTAL cash receipts from service operations	990,000	1,540,000	1,140,000	
Cash disbursed for service operations	(860,000)	(940,000)	(1,000,000)	
Cash available after service operations	130,000	600,000	140,000	
Other cash disbursed for non-service activities (capital purchases, funded depreciation)	(180,000)	(610,000)	(180,000)	
Net cash gain (loss)	(50,000)	(10,000)	(40,000)	
Beginning cash balance	390,000	50,000	40,000	
Cumulative cash	340,000	40,000	0	
Desired level of cash	300,000	100,000	100,000	
Cash above minimum financing needs	40,000	(60,000)	(100,000)	

Variance Analysis Performance Indicators

In addition to traditional volume, revenue, and expense variance reporting, whether by specialty or by sub account, the following illustrates the key performance indicators for the entity.

<table>
<tr><th colspan="2">Performance Indicators</th></tr>
<tr><td>PRICE INDICATORS

Price per visit = net outpatient revenue / total outpatient visits

Bad debt and charity care percentage = Bad debt + charity care / Gross patient revenue

Outpatient revenue State Funded % = net State outpatient revenue / Total net revenue

Other revenue % = other net revenue / Total revenue</td><td>EFFICIENCY

FTE's per visit = FTE's / average daily visits

Outpatient labor hours per visit = outpatient FTE's x 1950* / total outpatient visits

UNIT COST PER INPUTS

Salary per FTE = Salaries / FTEs

Taxes Paid/FTE = Total Taxes Paid / Total Visits</td></tr>
<tr><td>VOLUME INDICATORS

Operating Room Usage rate = Actual Level III Usage / Operating Room Capacity

Average daily visit volume (shown by day/mth./qtr.) = Total Visits / working days

Level I, II, or III Visit Rate = Level I, II, or III Visits / total visits</td><td>OTHER KEY INDICATORS

Referrals per Physician by Specialty = Number of Referrals / Physician FTE

Profit per visit = outpatient net revenue - outpatient costs / total visits</td></tr>
<tr><td>INTENSITY OF SERVICE

Method 1: Cost per visit by Level I, II, III = outpatient operating expens / total visits by each Level

Method 2: Cost per visit by Level I, II, III = 1995 Cost Object Costs / 1996 Cost Object -Actuals</td><td>NOTES:

FTE = full-time equivalent labor

*number of hours worked per person per year = 260 days per year X 7.5 hours per day = 1950 hours

Non-productive hours: vacation hours, sick hours, holiday hours, idle hours</td></tr>
</table>

These indicators need to monitored on a fairly frequent basis, at least quarterly and if possible, monthly. Managers can monitor actual performance in all of these areas by tracking:

Trends: Monitoring changes in various budgeted items in the facility over time.

Exceptions: Comparisons of actual indicator values to budgeted values. When significant deviations occur, some management action should be taken to correct the situation.

Benchmarks: Comparing own health facility indicators with comparable budget statistics of other similar well-functioning health facilities.

Internal performance: Monitoring whether budget goals and other targets established internally have been met.

4.2 Pricing and the Evaluation of alternatives

Unfortunately for the Polyclinic, acceptable price levels are not always a function of costs. The depressed economic nature of the region dictated the need for some flexibility in setting and collecting fees based on costs. The where-with-all of patients to pay was a dominant factor in price determination. However, costs were developed and price ranges were set based on the cost accounting functions produced during this and the previous field work. Special attention was paid to variable cost determination so that at minimum, non-fixed costs could be recouped.

Eighteen cost objects within a total of six specialty areas were developed. Included in the cost calculation was an estimate of the variable costs, including an estimate of revenue based taxes (VAT). The costs and their manipulation for pricing purposes, as well as the evaluation of alternative investment/divestment decisions, is shown in the next section.

4.3 Cost Accounting and Cost Calculations

RVU costing was selected as the preferred methodology of costing for this management accounting model. The RVU approach is a mathematical method for assigning costs to cost objects. Each cost object is first assigned a *relative value*. (1, 2, 3, etc.) The *relative value* is indicative of the amount of costs one cost object consumes verses another. (Example: A "4" consumes twice as much costs as a "2") When the *relative value* is multiplied times the volume of each cost object, a pro-rata share of costs can be allocated to each cost object. Key to the RVU method is the determination of the *Relative Value* for each cost object. The benefits of the RVU method of costing are summarized below.

- Manages cost distortions well
- Allows considerable flexibility in selecting and defining cost objects
- Provides a rapid, easily maintained methodology for costing
- Simplifies the costing process
- Suitable for a diverse organization such as a hospital or polyclinic

Two methods are typically used to develop the RVU (1) The "ranking" method and (2) he "objective data" method. Both methods were used in this field work. The ranking method sequences each cost object in order of its relative consumption of resources. Typically, an

ranking is established for cost object within a variety of groups of costs such as for labor, utilities, medicines, equipment etc. After the ranking, an estimate of the RVU is made which considers the ranking and any other judgment on the part of the manager. In the example below, three categories of surgery were defined: Level I, II, and III. Level III is the most complicated and involved while level I is the least complicated. After the ranking method was applied, the objective data method was implemented adding to the confidence of the cost accuracy.

In this case, the Surgery Manager was asked an *"If...Then"* question. For example:

> **If salary costs for a Level I Surgery are 1.0, then salary costs for a Level II is** ??? (1.5) **and Level II is** ??? (2.0)
> **If utility costs for a Level I Surgery are 1.0, then utility costs for a Level II is** ??? (2.0) **and Level II is** ??? (3.0)

Ranking required an experienced group of individuals who, through their professional judgment can *estimate* the relative consumption of costs. Most experienced managers can provide accurate rankings and estimates and it was felt this was clearly the case during the field work.

Estimating the RVU using more "objective data" was then accomplished. Rather than ranking and estimating the RVU based on experience and judgment, the use of more tangible data was seen as a second, more independent alternative. For example, a Level II surgery consumes a variety of costs including medicines and labor. Using the objective data method would require the determination of the medicines consumed, or minutes of labor involved. The

simple example below illustrates how three cost objects can be costed using such a methodology.

Labor RVU Analysis using more objective data

Hours of labor for a Level I	= .10
Hours of labor for a Level II	= .15
Hours of labor for a Level III	= .20
TOTAL HOURS	**= .45**
TOTAL Number of Cost Objects	= 3
Average Labor/Cost Object	= .15

Therefore the RVU would be:

	Mathematics	
A Level I	.10 **divided by** .15	= 0.66
A Level II	.15 **divided by** .15	= 1.00
A Level III	.20 **divided by** .15	= 1.33

The format and cost accounting calculation worksheet concept is provided in the Annex to this document. The Department requested not to "publish" their actual costs.

5. Internal Control

A primary concern of the field work was to have managers recognize not only the need to make better decisions within their organization, but to implement processes that promote the ongoing success of their decision making in an environment that is not *out of control*. In this regard, the field work was also targeted at coordinating the methods and measures required and regulated within the Ukraine and to adopt those and other standards of control as required to safeguard its assets, check the reliability and accuracy of its accounting data, promote operational efficiency and effectiveness and encourage the adherence to prescribed managerial policies. The rationale employed was: *by promoting operational control, the likelihood of consistently reaping the benefits of sound management decision-making increases.*

5.1 Internal Control Principles, Tools, and Techniques

It has become widely accepted by the management that benefits of internal control seek to provide health care managers with measurable and reasonable assurances regarding the achievement of effective and efficient operations. In addition, control was recognized as important to insure sufficient control within an organization exists to assure the reliability of financial reporting results to various external organizations in support of applicable laws and regulations

Once operations of the private entity begin, these two benefits can be realized as the designed control procedures are implemented over key operational processes that effect the financial and operational success of a health care organization. In addition, the internal control procedures more specifically seek to minimize the risks of unauthorized acquisition, use or disposition of assets. In other words, the internal control procedures identified also seek to prevent fraud or minimally identify and help detect fraud in a more timely manner. Briefly, the objectives of internal control can be summarized as:

- Attempting to insure all transactions are authorized such as the collection and management of user fees. For example, all user fees should be tracked and accounted for on proper receipts.
- Insuring all documentation and accountability for assets are in conformity with local and national laws and procedural requirements. For example, the use of only authorized forms and competed in accordance with known laws and regulations.
  Preventing unauthorized access to assets such as cash or medicine inventories without proper authorization. Not only should the internal control system prevent unauthorized access to such items as cash, but should equally prevent the access to nonasset items such as receipts.
- Insuring the recorded accountability of assets such as verification the cash amounts on hand are periodically compared and tested against actual amounts and the appropriate action is taken for any discrepancy(s). In addition, it is important the internal control system insures the timely posting of transactions so as to promote control.

There were five main procedures considered when establishing the controls. They were:

- Establishing a system(s) for authorizing transactions and activities. This is normally accomplished through a written policy with the approval of senior management members. In this case, medicine management was initially documented with an appropriate policy and flowchart.
- Segregation of duties that reduce the opportunity to allow any one person to be in a position to perpetrate and/or conceal errors or irregularities in the normal course of his/her duties by assigning different people the responsibility of authorizing transactions, recording transactions, and maintaining custody of assets, where possible.
- Design and proper use o f adequate documents and records to help insure the proper recording of transactions and events.
- Adequate safeguards over access to and use of assets and records such as having access to cash or medicine inventories, as well as having access to records and documentation and record keeping files.
- Independent checks on the internal control process(es) and periodic validation through auditing to insure records reflect assets and a reconciliation of assets and records is accurate and balanced. Those performing the periodic audits should be familiar with the internal control process but not be a part of the process. In other words, the auditor should be somewhat "independent" from those involved in the process.

Finally, the management of this health care organization considered the size, complexity, diversity of services and applicable legal requirements when designing internal controls. Generally, the larger and more complex an organization, the more elaborate the internal control structure. A priority within the department was to create a management *culture* of internal control. In all cases, the implementation of an internal control structure needs to occur over time in a prioritized manner. The decisions as to which internal controls should be implemented first was a result of the assessment of risk, including the risk of violating external laws and regulations. These laws and regulations are considerable in the Ukraine, and a copy of applicable laws was collected and evaluated. The laws and internal control regulations are provided in the Annex and highlight cash and medicine/inventory internal control. The following pages represent checklists developed earlier in this regard. The checklists are used to verify/audit the controls that are in place.

General Control Environment Questionnaire

	ANSWER			BASIS FOR ANSWER		
Question	*Yes*	*No*	*N/A*	*Observation*	*Discussion*	*Testing*
1. **Does the health care organization have an organizational chart**?						
2. **Does the organization have a chart of accounts o an organized financial accounting system**?						
3. **Are there accounting and internal control manuals and do they set forth accounting procedures**?						
4. **Does the organization have a controller or chief accountant**?						
5. **Does the organization have an internal auditor o** equivalent **person**?						
6. **If there is an internal auditor, is he/she independent from the internal control processes**'						
7. **If there is an internal auditor, are there internal audit reports available**? Have **they been reviewe recently**?						
8. **Is the general accounting and bookkeeping department completely separate from the cash receipts and cash disbursement function**?						
9. **Is the general accounting and bookkeeping department separate from the purchasing or operational departments**?						
10. **Are regular vacations required on those who have control over the operational and financial cash, bookkeeping, asset and/or record keeping control**? **(vacations often cause others to notice discrepancies)**						
11. **If regular vacations are not required, are the regular duties of these key individuals temporarily assigned to others**?						
12. **Does the head office of other organizations retai adequate control over any branch facilities**?						
13. **Are expenses and costs under budgeted control**? **In other words, is there a budget plan to which others can compare performance**?						
14. **Are key and material bookkeeping entries approved by senior management personnel**?						
15. **Are periodic financial statements prepared and submitted to management**?						
16. **If so are they designed to alert management as t significant fluctuations in costs, revenues, assets, etc.**?						
17. **List the names of those employees exercising the following functions:**						

Accountant _____
Cashier _____
Internal Auditor _____
Shipping _____
Purchasing _____
Receiving _____
Payroll _____
Tax _____
Department Head _____

Are any of these functions performed by the same person?

Notes:

Internal Control Questionnaire for Cash Management

Question	ANSWER			BASIS FOR ANSWER		
	Yes	*No*	*N/A*	*Observation*	*Discussion*	*Testing*
1. **Is there a separate accounting department from the cashier**?						
2. **Is there a ledger system of accounting**?						
3. **Is the accounting system maintained by a trained bookkeeper and/or accountant**?						
4. **Is there a safe location for cash deposits such as bank or safe**?						
5. **Does the facility deposit each days receipts without delay**?						
6. **Where is the deposit made**? **(bank, safe, etc.)**						
7. **Are deposits deposited by someone other than th cashier or bookkeeper**?						
8. **Does a responsible employee other than the cashier (depositor) investigate any debits from th deposit location**?						
9. **Are the cashiers duties segregated from the recording of the cash receipt or accounts receivable**?						
10. **Does an employee other than the cashier's department make entries into the ledger**?						
11. **Do the procedures prohibit the cashier from gaining access to the accounts receivable ledgers and monthly bank/safe and/or customer statements**?						
12. **Does someone other than the cashier handle the petty cash fund**? **The repair fund**? **The payroll fund**? **Etc.**						
13. **Identify the funds that are handled by the cashie (or the same person)**						
14. **Does a select group of individuals retain the righ to have the exclusive right to withdraw funds**? **I not, note who else does have such rights. (Government etc.)**						
15. **Is there a withdrawal co-signature authority process**?						
16. **Do strong controls exist that highlight when cash should be received but was not**?						
17. **Does the cashier assume full responsibility for th receipts from the time they are received until the time they are handed over for deposit**?						
18. **Is the cash adequately safeguarded (physically) within the facility**?						
19. **Does a proper segregation exist between those employees having access to patient funds (cash) and those employees having access to non-patien funds (such as payroll accounts)**?						

Internal Control for Cash Receipts

Question	ANSWER Yes	No	N/A	BASIS FOR ANSWER Observation	Discussion	Testing
Cash Receipts						
1. **Is an independent listing of cash receipts prepar before they are submitted to the cashier or bookkeeper**?						
2. **Does a third party verify this listing against the deposit slips before it is deposited**?						
3. **Are cash receipts deposited intact each day**?						
4. **Do procedures restrict the accounts receivable bookkeeper from...**						
5. **Preparing the bank deposit**?						
6. **Obtaining access to the cash receipts book**?						
7. H**aving access to collections from customers**?						
8. **When cash sales occur**, **do...all receipts have pre numbered identification**?						
9. **Are all receipts accounted for daily and matched with the cash collections**?						
10. **Are authenticated duplicates of the deposit slips retained and reconciled to the corresponding amounts in the cash receipts records**?						
11. **Does someone prepare a daily report of cash balances**?						
12. **Is the bank deposit made by someone other than the cashier or bookkeeper**?						
13. **Do proper controls exist pertaining to unsatisfactory payments by the patients**?						
Methods						
1. **Are receipts of currency immaterial**?						
2. **Are receipts recorded by cash registers or other mechanical device**?						
3. **If so**, **are the machine totals independently verified by others outside of the area**?						
4. **Does the facility use sales or cash receipt books**?						
5. **If so**, **are they...Pre-numbered**?						
6. **Does a non-cashier-type person independently check the numerical sequence and daily totals**?						
7. **Are the receipts matched with the cash collections**?						
8. **Are the unused receipt books properly safeguarded**?						
9. **If none of the above is used**, **is some equivalent system used**? **Explain.**						
10. **Do adequate controls exist preventing misappropriations of cash by the cashier such as fictitious discounts**, **waivers**, **allowances**, **etc.**						
11. **Do the receipts of miscellaneous receipts of cash such as from the sale of equipment report them t the accounting department and the cashier**?						
12. **Are those reports compared to the related cash and bookkeeping entries independently by the accounting department**?						

Internal Control Questionnaire- Medical Inventories and Supplies

Question	ANSWER			BASIS FOR ANSWER		
	Yes	*No*	*N/A*	*Observation*	*Discussion*	*Testing*
1. **Are the following items kept under the strict control of a few designated employees? Medicines? Bandages? Topical ointments? Gases? Disposable and reusable medical instruments such as syringes and needles?**						
2. **If practical, are inventories recorded monthly in bookkeeping or other accounting records?**						
3. **Are receiving reports or notifications made on th arrival of new medicines or other inventory items?**						
4. **Are receipts for issuance made for withdrawal of inventories?**						
5. **Are withdrawals allowed only under a specific system of designated authorizations?**						
6. **Are adequate inventory levels maintained?**						
7. **Are physical inventories taken at least yearly? (o periodically within the year?)**						
8. **Is the inventory supervised by an independent manager or equivalent?**						
9. **Is the merchandise labeled and classified properly?**						
10. **During inventories of larger stores, are pre-numbered inventory tags used to equivalent system?**						
11. **Is an overall review periodically made of slow moving or obsolete inventory?**						
12. **Are adequate accounting control made of items kept in patient areas? (near nursing areas, for example)**						
13. **If periodic inventories are maintained, are they annually reconciled to actual amounts by means of a complete physical inventory?**						
14. **Do all inventory records show quantities, unit costs, and aggregate values?**						
15. **Are the inventory records maintained and accessible by individuals other than those who have access to the inventory?**						
16. **Have there been any reports of inventory theft?**						
17. **Are inventories maintained in more centralized storage areas or are they disbursed throughout t facility?**						

Based on all of the information above, comment on the adequacy of internal control. For all weakness indicated, recommend corrective actions that should be taken. Update this checklist to monitor the weakness.

Originally prepared by: **Date:**
Reviewed in subsequent examination by:

Notes:

Internal Control Questionnaire- Payroll

Question	ANSWER Yes	No	N/A	BASIS FOR ANSWER Observation	Discussion	Testing
1. **Does the organization use time clocks, signed time cards, or equivalent?**						
2. **If so, are the documents above c completed by th employee and signed each pay period by the supervising manager or department head?**						
3. **Are the time cards controlled by the payroll department?**						
4. **Are test checks made of employee records and production of work?**						
5. **Are timecards compared to actual employees? Do they match? (no fictitious employees)**						
6. **Is more than one employee involved in the preparation of timecards and payroll?**						
7. **Are payroll duties effectively rotated?**						
8. **Are vacations of payroll clerks enforced?**						
9. **Are wage rates authorized in writing by the designated supervising manager?**						
10. **Is the payroll double checked as to the hours worked, rates, payroll deductions,, and taxes?**						
11. **If the payroll is delivered y check are the checks pre-numbered? Are blank checks in a secure area?**						
12. **Is the payroll bank account reconciled by someone other than the individual who prepares the payroll, delivers the payroll, or signs the checks?**						
13. **If cash wages are paid, are payroll receipts maintained by employees?**						
14. **Are the workers identified by their supervisors o other system for validating employment?**						
15. **Is the system for employment validate in control**						
16. **Is the distribution of the payroll periodically rotated among other employees?**						
17. **Are unclaimed wages relatively insignificant?**						
18. **Are audits of the payroll system periodically made by outside "independent" auditors?**						
19. **During disbursement of cash payrolls, is the area of disbursement secure?**						
20. **Have there been sudden payroll fluctuations within certain departments?**						
21. **Are payroll checks or cash disbursements only picked up by the employee?**						
22. **Is the process for adding an employee to the payroll in control and done through cross-authorization procedures? (more than one management signature?**						
23. **Do cash records of payroll match bookkeeping records and reconcile to bank amounts?**						
24. **Other**						

Notes:

Internal Control Questionnaire- Purchases and Expense Management

Question	ANSWER Yes	No	N/A	BASIS FOR ANSWER Observation	Discussion	Testing
1. **Does the clinic have a designated purchasing department/individual**?						
2. **If so, is it independent of the accounting department**?						
3. **Is it independent of the receiving department**?						
4. **Is it independent of the shipping department**?						
5. **Are purchases made only after respective authorization signatures according to a within policy are made**?						
6. **Are all significant purchases channeled through the purchasing department**?						
7. **Are purchase orders authorizations required of significant purchases**?						
8. **Do certain items get purchased through competitive bidding**?						
9. **If so, is the review made of the these ids independent and objective**?						
10. **Are purchase prices thoroughly reviewed and checked by a knowledgeable employee**						
11. **At the time of receipt, are purchased quantities checked against actual receipt quantity**?						
12. **Is the receiving department denied access to the purchasing records**?						
13. **Does the receiving department fill out the receip of goods documentation**?						
14. **Are copies of the receiving reports sent to the accounting or bookkeeping department If not, how are accounting records updated**?						
15. **Are copies of the receiving reports sent to the purchasing department If not, how are purchasi orders reconciled to actual goods received**?						
16. **When goods are returned to vendors, are credits obtained**?						
17. **Are there only a few, non-material unmatched purchased orders with receiving reports**/						
18. **Do safeguards exist for the proper accounting of partial shipments being received against orders**?						
19. **Does a responsible official approve payment of purchasing orders**?						
20. **If purchases are paid directly out of cash, is the system for purchase authorization, inventory receipt, quantity verification, and cash disbursement authorization intact, independent of each other and capable of being tracked**?						
21. **Does the accounting system support sufficient account classification detail to test and validate where expenses were booked versus what was paid out**?						
22. **For items that are not "tangible" such as electricity and heating utilities, is there any reconciliation of amounts paid with amounts consumed**?						

Notes:

Internal Control Questionnaire- Petty Cash Fund Management

Question	ANSWER Yes	No	N/A	BASIS FOR ANSWER Observation	Discussion	Testing
1. **Does the organization use an imprest cash fund? (this is a fund where receipts/voucher are maintained for each expenses)**						
2. **Are the petty cash slips pre-numbered**?						
3. **Do different employees periodically take charge of the fund**?						
4. **Is the amount of the petty cash fund all enough s as to make periodic replenishment a frequent occurrence**?						
5. **Is there a maximum amount tat may be drawn from the petty cash fund**?						
6. **If so, state the amount.**						
7. **Are receipts/vouchers maintained for each expense**?						
8. **D regulations prohibit the cashing of payroll checks from the fund, or the exchange of selected currencies within the fund**?						
9. **Does an independent and responsible employee reconcile the total vouchers, with the remaining cash amountsbefore replenishing the fund**?/						
10. **Do the vouchers explain the nature of the expense, as well as have the amount written out in words**?						
11. **Is only the custodian of the petty cash fund have authorization to sign receipts/vouchers and authorize disbursements**?						
12. **Are surprise checks f the petty cash fund performed**?						
13. H**as there been abuse of such funds before and have steps been taken to correct the situation**?						
14. **Other**						
15. **Other**						
16. **Other**						
17. **Other**						

Based on all of the information above, comment on the adequacy of internal control. For all weakness indicated, recommend corrective actions that should be taken. Update this checklist to monitor the weakness.

Originally prepared by: **Date:**
Reviewed in subsequent examination by:

Notes:

ANNEXES

A) Summary of Tax Liabilities for a Private Clinic in the Ukraine
B) Financial Model- Private Entity Reporting Model & Requirements
C) Financial Model- Public Entity Reporting Model & Requirements
D) Sample Ministry of Health Licensing Documentation
E) Organization Charts
F) Sample Job Descriptions
G) Sample Set of Bylaws (for the newly formed entity)
H) Physician Incentive System- Shown by Phases
I) Definition of Service Levels by Specialty
J) Cost Accounting Model
K) Internal Control Regulations - Cash, Medicines, and Equipment
L) Contacts
M) Documents Used
N) Daily Log

ANNEX A

Summary of Tax Liabilities for a Private Clinic in the Ukraine

The following summary presents the majority of taxes paid by health care enterprises desiring to operate in a private manner in the Ukraine as of the start of 1996. This summary is by no means the "finite" list of all potential tax liabilities. The summary is meant to provide the reader with an overview of the variety, type and nature of the majority of taxes being paid by such enterprises. For example, certain facilities are subject to a "land" tax based on property values/land fertility while other institutions importing foreign equipment could be subject to other taxes such as import or duty taxes. None the less, the following provides useful insight into the scope of taxes being commonly collected.

These taxes can be categorized into four groups.

- Taxes based on salary expenses *
  - 37% Social Security Tax *(.37 times salary expense)*
  - 12% Chernobyl Tax *(.12 times salary expense)*
  - 2% Employment Fund Tax *(.02 times salary expense)*
- Taxes based on User Fee (service revenue) volume
  - 16.67% VAT (value-added taxes) *(.1667 times gross user fee revenue)*
  - 1.2% Post VAT Road Fund Tax *[(Gross User Fees times .1667) times .012]*
  - 1.0% Post VAT Labor Protection Fund Tax *[(Gross User Fees times .1667) times .01]*
  - 1.0% Post VAT Innovation Fund Tax *[(Gross User Fees times .1667) times .01]*
- Other Taxes
  - 10% Communal Tax *[(Number of FTE's times untaxed salary amount (or 1,700,000 koupons)) times 10%]*
  - 25% Depreciation Tax (*25% of budgeted depreciation)*
- Income Taxes
  - 30% Income tax (after expenses including the above taxes)

* There are three (3) taxes based on the entity's salary expense. A 37% levy for social security tax of which 88% goes to fund pensions and 12% to other social services.

Taxation Calculation Example: Annex A Continued

A 10 employee clinic collected $10,000 of revenue. Assume the following expenses were paid/incurred during the year: $4000 of paid salary expense ($33 per month per employee), $500 of depreciation expense, $1000 of paid medical supply expenses, utilities, and all other operating expenses.

Taxable Base	***Tax Name***	***Amount (rounded)***
User Fees	VAT (16.67%)	$1667
User Fees	Road Tax (1.2%)	$100
User Fees	Labor Pro. Tax (1.0%)	$83
User Fees	Innovation Fund (1.0%)	$83
Salary Expense	Social Security Tax (37%)	$1480
Salary Expense	Chernobyl (12%)	$480
Salary Expense	Employment Fund (2%)	$80
Depreciation Expense	Depreciation Tax (.25%)	$125
FTE's (x) 1700000 Kps	Communal Tax (10%)	$9
Gross Taxes before Income Tax		***$4107***
Residual Subject to 30% income tax		***$393***
FINAL PROFIT		***$275***

ANNEX B

Financial Model- Private Reporting Requirements

The financial accounting requirements of the region dictate the form and substance of financial reporting. Thus, a definition of, and preparation for, these reporting requirements was necessary. The following is a list of the key financial reporting requirements of a private entity operating in the Ukraine. Following this list is a set of the required forms and format, with supporting worksheets, component funding, and expense calculations. Annex C provides a complete set of the financial reporting documents for a *public* institution.

PRIVATE ENTERPRISE
KEY FINANCIAL REPORTING MODEL

Balance Sheet

ASSETS

I. Main means and other non-turn-over assets
II. Stocks and expenses
III. Cash funds, payments and other assets - Ending Balance

Liabilities

I. Enterprises funds sources or
II. Long-term liabilities
III. Payments and other liabilities - Ending Balance

REPORTS
On Financial Results / Utilization

I. Financial results
II. Profit utilization
III. Budget payments
IV. Tax credits and deductions
V. Tax advantages (exceptions) on the profit

REPORTS
On the Finances and Assets of the Enterprise

!. Funds movement
2. **Budget and non-budget funds utilization**
3. **Funds allocation to the target and non-budget funds and consumption**
4. **Existence and movement of the main assets**
5. **Existence and movement of non-material assets**
6. **Financial investments**
7. **Standard of the turnover costs of the enterprise**, (590)
8. **Existence of the turnover funds of the enterprise**,(595)

9. **Re-evaluation of the goods-material merchandise and goods**
10. **Foreign investments**
11. **Shortage, theft and deterioration of the merchandise**
12. **Housing and social-cultural facilities**
13. **Non-balance assets and liabilities**

OTHER REPORTS - *Private Entity Financial Reports* - ANNEX B Continued

BARTER TRANSACTIONS
DECLARATION
INCENTIVE TAX CALCULATIONS
VAT STATEMENT (monthly)
DONATIONS TO THE CHERNOBYL FUND ASSOCIATION
DONATIONS TO INNOVATION FUND
CALCULATION OF DONATIONS TO LABOR PROTECTION FUNDS
CERTIFICATE
...on the target utilization of funds, non-material funds and merchandise received as irretrievable financial aid or voluntary donations
DONATIONS
…**to the National Employment Fund**
PAYMENT
…**for special utilization of the fresh water resources**
STATISTIC BUDGET (monthly)
LABOR REPORT
STATEMENT
…**on the VAT and Excise Tax on imported goods**
PAYMENT
…**for the Excise Tax**
STATEMENT
…**on the hard currency assets and property belonging to the resident of Ukraine located beyond its borders**
STATE STATISTIC REPORTING
ROAD TAX
STATEMENT
…**on the calculation of insurance fees and pension fund spending**
PAYMENTS
…**to other social funds** (37% **for Social Needs**)
LABOR STATEMENT
…**for the joint ventures**
STATEMENT
…**on the VAT for intermediate enterprises**

PLEASE INSERT 33 PAGES
OF ALL PRIVATE FINANCIAL REPORTS
AND SUPPORTING WORKSHEETS

ANNEX B - CONTINUED

ANNEX C.

Key Financial Model- Public Reporting Requirements

The following is a list of the key financial reporting requirements of public entity operating in the Ukraine. Copies of the required forms and format are also provided, with supporting worksheets and component funding and expense calculations.

BALANCE SHEET

ASSETS

I. Capital Assets
II. Materials and Supplies
III. Incidental Assets with Short Lives
IV. Production and other expenses
V. Cash Assets
VI. Payments
II. Expenses
VIII. Losses
IX. Expenses for Capital Construction - Ending Balance

LIABILITIES

I. Financing
II. Target Funds
III. Settlements
IV. Realized Products and Revenues
V. Financing the Capital Construction
Non-balance Accounts - Ending Balance

REPORT
…**On the budget funds circulation on sub-accounts**

REPORT
…**On the movement of the capital assets**

REPORT
…**On the movement of merchandise**

REPORT
…**On the enterprise expenses**

REPORT
…**On the special funds**

REPORT
…**On the remaining, received and submitted to the State Funds precious metals as scrap and waste.**

PLEASE INSERT 14 PAGES
OF ALL PUBLIC FINANCIAL REPORTS
AND SUPPORTING WORKSHEETS

ANNEX C - CONTINUED

ANNEX D

PLEASE INSERT 4 PAGES OF

Sample Ministry of Health Licensing Documentation

These 4 pages consist of:

- A Letter of Application
- Proof of Entity & Ownership
- Listing of Services Provided
- License

ANNEX E

PLEASE INSERT 2 PAGES

Organization Charts

These 2 pages consist of:

- An Operational Organization Chart of the Department of Surgery
- An Ownership and Control Chart

ANNEX F.

PLEASE INSERT

Sample set of Job Descriptions
3 Descriptions

These 3 descriptions consist of:

- Job Description of the *Department Head*
- Job Description of the *Financial Director*
- Job Description of the *Head Nurse*

ANNEX G.

PLEASE INSERT

Set of Entity Bylaws

15 PAGES

ANNEX H

Department of Surgery
Introduction of a Phased-In Physician Incentive Payment Program.
Phases of Implementation

The phased-in incentive system for physician payments shall be implemented during the first six months of the entity's life. The phased approach reflects management's initial focus on some fundamental concerns, and, once these are resolved, to rapidly migrate toward more refined measures of linking pay with performance. In short, management believes there is a necessary sequence to building an effective organization including an incentive system.

Phase I is expected to last 1 to 2 months and shall focus on the work time and attendance of physicians. Time and attendance management, which is a current operational problem and is seen as an important issue to resolve before more refined incentives can be implemented, will be accomplished through the introduction of a regulated attendance monitoring system supervised within the newly formed entity. Base pay will be set on a defined minimum number of hours and days for each physician in coordination with the Polyclinic's operating schedules. Phase II, occurring in months 3 & 4, will expand the incentive system to link payments to the complexity (intensity) of the services. In addition to meeting gross volume goals of services based on patient visits, there was a desire to reward those physicians who deliver medical services whose intensity of service is above the level of a normal "office visit". The intensity of services will be defined by a three level classification system, with each class reflecting a higher level of intensity and the resulting payment based on a relative point system. Phase III will continue this process with a tighter control on quality and effectiveness and efficiency within each level of service Quality definition and measurement will be accomplished on a committee peer review process. The peer review process is intended to build consensus among the medical staff as to the measures and processes in which quality can be defined including the appropriateness of care and referral patterns. The phases are summarized on the following page.

ANNEX H- *continued*
Department of Surgery
Introduction of a Phased-In Physician Incentive Payment Program.
Phases of Implementation

Phase I

TIMEFRAME: Month 1 & 2

Primary focus on:

- Meeting scheduled office hour requirements
- Work attendance
- Monitoring visit volume
- Only actual working hours will be paid

To realize this :
- a system of registration of billable hours is to be implemented
- an independent committee shall be created from the employees to control the observance of working hours.

Phase II

TIMEFRAME: Month 3 & 4

Primary focus on:

- Introduction of the physician payment linked to the level of service complexity
- And the level of time invested

To realize this :

-a peer review committee establishing and refining levels of service intensity with measurable criteria for quality and outcome assessment shall be formed among employees
- a system of assessment of nurse's performance (nurses salary shall not depend on the effectiveness and quality of physician's performance) shall be implemented.

Phase III

TIMEFRAME: Month 5 & 6

Primary focus on:

- Linking the physician payment to also be dependent on the quality and effectiveness of physicians performance where not only are levels of services tabulated, but the process quality and outcome measurements decided by the peer committee in Phase II are reviewed.

ANNEX I
DEFINITION OF SERVICE LEVELS BY SPECIALITY
DEPARTMENT OF SURGERY
POLYCLINIC No. 2
(Translated Version from L'viv -
Ukraine version attached)

The following is an initial definition of service levels shown by specialty. Also shown is the approximate percentage of patient volume. These volumes are consistent with the statistical budget formulated for 1996**.**

SURGERY

Level 1 (50% of physician activity)

- Preventive examination
  — pro-active examination of employees of companies
  — medical examination of patients referred to by other doctors
- Patient's examination in order to determine diagnosis and prescribe conservative treatment
- Treatment of patients with simple pustular diseases of skin and subcutaneous fat (furuncles, paronychia, subcutaneous withlow, .eruthematous form)
- Treatment of nonmalignant swellings of skin and subcutaneous fat (2 cm in diameter)
- Follow-up treatment of patients after inpatient uncomplicated surgeries

LEVEL II (40% of physician activity)

- Treatment of pyo-septic diseases (abscesses, carbuncles, phlegmons, thecal withlows, bony panaritium, post-injection abscesses , ingrown nails, mastitis, etc.)
- Follow-up treatment of post-operation complications after surgeries on thoracic and abdominal cavities
- Treatment of non-malignant swellings of skin and soft tissues (from 2 to 4 cm in diameter)
- Pleurocentesis; trachea puncture; microtracheostomia; puncture of cysts and hematomas; exploration punctures; and venesections.
- Blockades
- Arrest of bleeding:
- Primary and secondary medical treatment of purulent wounds
- Installation of gastric tube., Blackmore's tube,; vesical catheterization

LEVEL III (10 % of physician activity)

Operations performed in the out treatment surgical facility

- Operations on varicose veins on upper and inferior limbs

- Operations on groin, umbilicus , femoral and post-operational carinas; and white line carina;
- Operations on hydrocele after Vinkelman
- Operations on spermatic cord varicose veins ;
- Operations on phimosis, paraphimosis and short frenulum
- Secretium resection of milk glades — after biopsy with histological issue
- Hemotrrhoidsektomy after Milligan-Morgan
- Excise of bone
- Excise of anal fissure and other

TRAUMATOLOGY

LEVEL I (50% of physician activity)

- Examination of a patient, determination of diagnosis and prescription of conservative treatment.
- Consultative examination
- Treatment of inflamed joint, except those with deforming damages.
- Treatment of dislocations and fractures which did not cause the displacement of minor joints and bones.
- Initial surgical treatment of traumas without damaged tendons, muscles or bones.
- Treatment of inflamed periosteums, tendons and tendovaginitis.
- Setting of regular dislocations

LEVEL II (45% of physician activity)

- Treatment of shoulder dislocation, subluxation of talocrural articulation and congenial dislocation of ..... joints.
- Treatment of fracture of upper and inferior limbs with displaced bone fragments.
- Initial surgical treatment of traumas and injuries with subsequent damage of tendons, muscles and bones.
- Treatment of deformed joints
- Diagnostic and medical puncture of joints.
- Arrest of bleeding

LEVEL III (5% of physician activity)

Operations included in an expanded list services to be offered in the out treatment surgical facility.

- Meniscectomy for meniscus laceration
- Operations on valgoid deformation of foot
- Operations on Dupuytrenis contracture
- Removal of metal parts after a metallosteosynthesis treatment of fractures

- Extraction of foreign bodies.
- Arthrodesis of minor joints.

UROLOGY

LEVEL I (45% of physician activity)

- Examination of a patient , determination of diagnosis and prescription of conservative treatment.
- Consultative examination of a patient.
- Simple diagnostic and medical manipulations: smear taking; prostate secretion taking.

LEVEL II (50% of physician activity)

- Diagnostic and medical manipulations:
  manipulation of prostate and seminal vesicles;
  prostate secretion microscopy;
  uretroscopy;
  cystoscopy;
  lavage of urinary bladder by medical substances;
  urethra bougieurage;
  urethra irrigation;
  bougie massage of urethra and prostate
- Blockades:
- Electric agulation of polips on external male and female genitals;
- Magnetic therapy for prostate disease.

LEVEL III (5% of physician activity)

Operations to be included into an expanded list of surgeries

- Operations on phimosis, paraphimosis and short frenulum;
- Operations of hydrocele;
- Operations on cryptorchidism
- Operation of spermatic cord vericose veins.

PROCTOLOGY

LEVEL I (40% of physican activity)

- Examination of a patient , determination of diagnosis
  (without instrumenal methods) and prescription of
  conservative treatment.

- Simple diagnostic and medical manipulations: digital and rectal mirror examinations, irrigation of rectoris and anal orifice with medicaments.
- Examination of anal fissures, cytologic examination of tumors
- Thrombus exemption out of thrombosed hemmorrhoids.

LEVEL II (55% of physician activity)

- Diagnostic and medical manipulations.
  - rectoromanoscopy
  - colonoscopy
  - electrocoagulation, dissection, cryotherapy of benign tumors
  - opening periproctitises, cysts
  - ligation of the hemmorrhoids at the crura
- Blockades : sacral and presacral
- Treatment after operations on large intestine.

LEVEL III (5% of phsyician acivity)

- Operations of the wider scope:
  - -Hemmorrhoidectomy
  - -Dissection of anal fissures
  - - Exemption of large and sigmoid intestines polyps
  - - Radical operations on cypric cruras
  - - Opening high periproctitis.

PLEASE INSERT ORIGINAL VERSION IN UKRAINE
5 PAGES HERE

ANNEX J

INSERT 4 SHEETS OF THE

COST ACCOUNTING MODEL

ANNEX K

INSERT INTERNAL CONTROL REGULATIONS & CHECKLISTS NUMEROUS PAGES IN UKRAINIAN COVERING CASH, MEDICINE, AND EQUIPMENT MANAGEMENT

INSERT 69 PAGES AS LISTED BELOW

The following documents are attached in Annex K

Decree:	Implementation of Labor Contracts
Decree:	All Employee Contracts
Decree:	The Management and Administration of Drugs and Prescriptions
Decree:	Selling Procedures for Distributing Pharmaceuticals
Decree:	Prescription Procedures for Internal Control
Internal Control:	Cash and Cash Transaction Audit
Internal Control:	Regulations on the Installation of Cash Machines
Internal Control:	Cash Machine Installation Procedures
Internal Control:	Temporary Regulations and Control of Cash Transactions - National Bank of Ukraine
Internal Control:	New regulations of Cash Transactions
Internal Control:	Determination of Cash Limits, Expense Norms, Cash Delivery & Collection of Cash
Internal Control:	Maximum Range of Cash Expenses
Decree:	Cash Machine Implementation Dates
Decree:	Cash Machine Management for User Fees
Decree:	Cash Machine Management - Amendment
Decree:	Using Cash Machines
Internal Control:	Medicine Management & Storage- With Flowchart
Internal Control:	Equipment Inventory Form(s)

ANNEX L

PERSONS CONTACTED

Zdrav*Reform*/L'viv

John Stevens, IDS Advisor
Borys Uspensky, IDS Technical Specialist
Marta Koval, Interpreter
Victor Katolyk, Interpreter
Helen Antonova, Interpreter (& Aviation Expert)
Olga Samoylenko, Secretary
Victoria Mouzytchuk, IDS Office Manager
Anatole Tkachuk, Driver

L'viv

Pavlenko Oleksandr- Lawyer- Law firm ASPI - L'viv, Ukraine

L'viv Medical University:

Alexander Sabin, Professor of Information Systems
Yaroslav Bazylevich, Chair, Management Department
Igor Tchaklosh, Chief Information Services
Ivan Furtak, Health Care Administration Departement
Vira Dyachyshyn, Deputy, Health Care Administration

Hospital Number 1:

Svitlana Bychenko, Chief Accountant

Polyclinic 2:

Dr. Yevheny Polataiko, Head Doctor
Dr. Taras Sheremeta, Head, Department of Surgery
Dr. Tetyna Obozhda, Deputy Administrator, Director of Services
Dr. Olinyk, Deputy Administrator of Polyclinic
Dr. Frina Lontyeva, Chief Doctor- Pediatrics
Dr. Roman Stets, Surgeon
Ms. Alla Zelinska, Chief Economist
Ivanna Balahina, Chief Accountant

L'viv Oblast/City

Ms. Yevgenia Medvedska, Chief of Planning and Finance-Oblast HC- KRU Audit
Pavel Tertuchnyi, Vice Manager, Regional Health Protection Council-Oblast
Dr. Mykola Khobzey, Chief of the L'viv Oblast Health Administration
Mr. Hobzar- City Health Care Administrator

Zdrav*Reform* Short-Term Personnel

Annemarie Wouters, Ph.D., Abt Associates Inc.
Marty Makinen, Ph.D., Abt Associates Inc.
Peter Cowley MD, MPH, Abt Associates, Inc.

Zdrav*Reform*/Kiev

Marc Stone, Director
Victor Omelchenko, Medical Advisor
Roman Ponos, Financial Director- ZRP Ukraine

Zdrav*Reform*/Bethesda

Peter Hauslohner, Ph.D., Abt Associates Inc.

Center for Pharamesuitical Economics/ University of Arizona Medical School

Barbara Else MPH
Michael Noel R.Ph. Director of Pharmacy-Kino Community Hospital

ANNEX M

LIST OF DOCUMENTS CONSULTED

"Task/Product Flow Chart, L'viv Demonstration Site", Zdrav*Reform* Program, Revision 3, October 23, 1995.

"On Implementation of Per Capita Financing", Regulation Issued by the Head of L'viv Oblast Administration, September 25, 1995.

“Internal Control and Cash Management”, Bradford Else, Zdrav*Reform* Program, November 1995.

“Institutinalizing Improved Cost Management and Internal Control Sysems in Polyclinic No. 2”, Bradford Else, Zdrav*Reform* Program, November, 1995.

“Generally Accepted Auditing Standards”, AICPA, 1995.

“Internal Control and Financial Statement Audits”, AICPA, 1991.

“Trip Report- Second Technical Assistance to Skole Rayon”, Cowley & Makinen, February, 1996.

“Management Accounting and Control: A Manual for health Care Organizations”, Task 053, Else & Wouters, January 26, 1996.

ANNEX N

Daily Log

Monday 2/19/96 - Meeting with Stevens, Wouters and L'viv office staff regarding Task 333 objectives, timing, and supporting resource requirements. Arranged agenda, translators, drivers, and meetings for week. In afternoon, met with Oleksandr Pavlenko (Privatization Lawyer), Dr. Taras Sheremeta (Polyclinic No. 2), Boris Ubesnsky (Abt-L'viv), and John Stevens (Abt L'viv) regarding legal status of privatized Department of Surgery in Polyclinic No. 2. Open issues drawn-up and follow-on meeting set.

Tuesday 2/20/96 - Met with translator. Prepared working documents for week. Went to Polyclinic No. 2. Met with Dr. Taras Sheremeta and Alla Zalinska. Reviewed organizational requirements for a private entity operating within a public institution, established a list of priorities for the field work, and reviewed legal obstacles and next steps..

Wednesday 2/21/96 - Met with Alla Zalinska, Chief Economist and began preparation of the financial reporting requirements for a public and private hospital including all required documents and reporting requirements in coordination with staff accountant. Followed-up with Dr. Sheremeta and then went to Medical University of L'viv (Bazelavich/Furtak) and gave a 45 minute talk to the Health Care Management Class of Hospital Directors from the Western Part of the Ukraine (45 people) on Pragmatic Internal Control and Cost Management including the role of health care informatics in management. Talk was well received with questions centering on the role and application of appropriate informatic planning which considers decision-making needs and priorities. Talk attended by medical newspaper personnel. Then met with Alexander Sabin, Head of the MIS Department at the University who was interested in building a health care informatics course for chief doctors and medical students. His interest was in merging the economic and medical needs of health care managers with an appropriate and realistic class agenda. Discussion centered on class agenda and a request for a copy of his course agenda was made. In evening, met with Stevens and addressed the many open issues of Polyclinic No. 2 privatization.

Thursday 2/22/96 - Spent another day with Zalinska and Sheremeta. Dr. Teets, the Surgical Proctologist joined the meeting in the afternoon. Work centered on all aspects of the Task. Updated Wouters on Task progress.

Friday 2/23/96 - Prepared revised RVU costing and budgeting agenda/suggestions for Privatized entity in morning. Went to Polyclinic No. 2 in afternoon and met with Privatization Lawyer Pavlenko and Polyclinic personnel on many open legal issues. Follow-on meeting with Department of Surgery. Updatd Stevens on open legal and organizational issues.

Saturday 2/23/96 - Began writing Trip Report most of the day and into the evening.

Sunday 2/24/96 - Worked in office in morning and hotel in afternoon arranging work for coming week, developing new cost accounting model, and more on the trip report. Evening took off and enjoyed the Opera.

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Monday 2/25/96 - Met with the audit arm of the Oblast Health Authority and reviewed the many internal control requirements of the governing authorities. Then proceeded direct to the Polyclinic to have follow-on management accounting meetings with the Department of Surgery, including Dr. Olinyk, the 1st Deputy of the Polyclinic No. 2.

Tuesday 2/26/96 - Met with the Dr. Politaiko, Head of the Polyclinic in the morning with Stevens, Sheremeta, Olinyk regarding the legal and organizational issues of the privatization effort. Set short term goals. Then met with Polyclinic accountant to review the financial reporting requirements of public and private facilities. In afternoon, meet with the 3rd Deputy of the Polyclinic who was also interested in applying management accounting concepts to all aspects of the "sick list" management which composes some 20% of all medical activity at the clinic. Follow-on evening meeting with Dr. Sheremeta. Updated Stevens on open legal and organizational issues.

Wednesday 2/27/96 - Medical University follow-up in the early morning with Dr. Bazelavich and Dr. Furtak. Saw a potential management computer model built by University. Then went to Polyclinic to revise revenue and expense budgets with Zalinska and Sheremeta. Contacted Kiev Abt office requesting assistance in outlining Ministry of Health process/reporting requirements for obtaining a "license to operate".

Thursday 2/28/96 - 14 hour day revising costs and management accounting reports. Coordinated follow-up with Polyclinic No. 2 after the end of this Task (333) with Kiev office.

Friday 2/29/96 - Met with Dr. Galina Borisova, Laboratory Director who was interested in applying management accounting techniques in her department. Follow-on meeting with entire Departmental of Surgery medical staff (14 attended) over-viewing progress to date, net steps, and answered their questions. Questions centered around whether the governmental authorities would allow such an privatized experiment to exist. Reviewed status of Task with Wouters and Trip Log scope, subject matter, and content.

Saturday 3/1/96 - Met Zalinska and Sheremeta in Abt L'viv office and finalized new cost, revenue and expense model for department. Worked with new translator on translation material. Updated Stevens on all aspects of Task in early evening, and then returned to hotel to work on Trip Report.

Sunday 3/2/96 - Worked in Hotel room all day (snow again!) Continued on Trip Report.

Monday 3/3//96 - Obtained Oblast audit division internal control documentation of Medicine Management and Control. Met with Sheremeta & Lawyer in afternoon at Abt office. Outlined pending obstacles, and agendas. Set up meeting with City authorities & Polyclinic No. 2 for Tuesday.

Tuesday 3/4/96 - Finalized draft of trip report. Went to Polyclinic No. 2 to overview conclusions and next steps. Went to City Health Authority with Stevens, Politaiko, Sheremeta to overview next steps. (decree) Reviewed for three hours the open issues in the evening with Sheremeta. Major snow storm in progress.

Wednesday 3/5/96 - Worked with Roman Ponos all day coordinating follow-up of privatization process over the coming 60 to 90 days. Went to Polyclinic No. 2 in afternoon to address the new open issues requested by the City during the previous day. Submitted draft trip report to Stevens as targeted.

Thursday 3/6/96 - Met with Stevens and Wouters in morning to provide conclusions/status of work and next steps. Left L'viv for Warsaw at noon.

To: John Stevens
CC: A. Wouters
From: Bradford Else
Re: One Page Recommendations for Privatization Follow-up as Requested
Date: March 3, 1996

Overview

Follow-up on the effort to privatize the Department of Surgery within the public Polyclinic No. 2 has two thrusts. First, to overcome the legal and administrative obstacles among all of the parties including national, regional, city, local, and participating parties. Second, to facilitate the success of the financial and management accounting models prior to and after the legal and administrative obstacles are overcome.

Legal and Administrative Follow-up

Nurture the legal and administrative process. **Legal and administrative obstacles during an environment of political and economic reform can be very slow and require a substantial amount of intervention, nurturing, and process involvement. Competently providing for an ongoing function (60 to 90 days) in this regard is seen as most useful. Specifically and in sequence:**

- **Finalize and obtain the Oblast decree (Coordinate, if required with City Decree)**
- **Finalize and obtain any supporting City decree**
- **Form the new entity**
- **Get the Agreement between the Polyclinic and the new entity signed**
- **Submit and obtain application to the Ministry of Health for a License to Operate**

Financial and Management Accounting Model Follow-up

Monitor the financial and management accounting models **and encourage revisions to the management accounting model as decision-making needs change. Management accounting is a dynamic field and should be adjusted as decision-making needs evolve. Operational improvement, particularly in the early days of establishing a more autonomous entity, is expected to be quite rapid during the initial period. Thus, changes in the management accounting model should be expected and encouraged. As important, is the timely and accurate compliance with the financial (external) reporting requirements. Specific assistance should include:**

- **Insure this trip report is translated within a short period of time so clinic managers can better coordinate their activities with ZRP staff**
- **Verify the entity is providing monthly financial reports**
- **Verify the entity is monitoring expected volumes, revenues, expenses, and cash requirements against actual levels.**
- **Verify taxes and tax forms are being prepared and submitted as required.**
- **Verify the written internal control policies and procedures are being followed, that spot audits by management are occurring, and that corrections are being followed.**
- **Insure the performance indicators are being followed as detailed in the trip report as well as periodic updates to the planning and control processes (budgets).**